2014

Rao Farman Ali

IPPRD

Consultancy: Institute of Public Policy Research and Development (IPPRD)

[THE DEPRIVED CHILDHOOD]

A Case Study of Orphans in Kashmir

Abstract

“Personality is the key factor in defining individual uniqueness and shaping an individual's course through life. Culture is the way of life. Culture is not only our conscious values, but also it's our assumptions about the way things are. Humans perceive and believe according to their cultural development. Culture represents one of the important factors of the personality modelling. The study of culture and personality seeks to understand the growth and development of personal or social identity as it relates to the surrounding social environment.

The cultural features of a society generate certain distinctive features in the children’s socialization. By using some common socializing elements and mechanisms, there may be formed common features of personality or a configuration of personality features typical for the members of a society. Within each society, there are one or several types of personality that the children have to copy.

The relation between culture and personality is obvious, while the personality forming marshes mostly in the internalisation of the elements of a culture. In a stable and integrated culture, the personality is an individual aspect of the culture, and the culture is a collective aspect of the personality. In each society, the dominant culture coexists with a certain number of subcultures and countercultures. The socialization made within a subculture adds specific elements to the modal personality features. Thus, there appear differentiated personalities in relation to the subcultures.”

The family is primary institution of socialisation within it child appropriates the social norms and values—becomes capable of having relations with the other members of the society. Culture represents one of the important factors of the personality modelling. The cultural features of a society generate certain distinctive features in the children's socialization. The external shock studies have mostly been related to armed clashes which come under the category of Peace and Conflict. During such clashes, the access to health services for pregnant women, including vaccinations, prenatal and antenatal care, and micro-nutrients needed for the foetus development, is limited. This adds to the already existing stress which adds up to limit the development of the child in uterus.[1]

Stress changes the production and distribution of hormones, including intrauterine growth hormones and can reduce the gestation time of the foetus. In countries under armed conflict the conflict related stresses make the already existing challenges to foetal development more acute.

Armed Conflicts take different forms depending on expediency of political diplomacy and the level of violence and actors involved. They can range from insurgencies to civil wars; from wars between two countries to world wars. In World War II the German individuals were more affected by allied bombings and younger ones learnt less than adults, besides, being shorter and less satisfied with their health.[2] This is further supplicated by regional variation in height for age z-scores for children in Iraq after the US invasion[3]. Children in more war affected regions are shorter, for instance the Children close to border regions of the Eritrean-Ethiopian border are shorter in both countries[4]. This indicates that war has bearing even on the height of the children.[5]

On the other hand psychologists agree that children with secure attachments to their parents have better chances to develop into happy, successful, and well-adjusted adults. Parents encourage their children to investigate the world, manipulate objects, and explore physical relationships. This helps in proper physical and emotional development of children.

The Literature on the Wrecked Childhood: There are various studies pertaining to orphans, in one of the study titled **"PSYCHIATRIC DISORDERS AMONG CHILDREN LIVING IN ORPHANAGES –EXPERIENCE FROM KASHMIR"**, children within the age group of 5 to 12 years were recorded. Post stress traumatic disorder (PSTD) was the commonest psychiatric disorder (40.62%) easily attributable to the prevailing mass trauma state of almost two decades. The next commonest diagnoses were Major Depressive Disorder (MDD) with 25% and Conversion Disorder (CD) with 12.5%[6]. The report says that there is a general agreement among researchers that children placed in special home settings at a young age and for long periods of time are at an increased rate of developing serious psychopathology later in life. Early behavioural disturbance is one of the strongest predictors of later problems, including psycho-logical difficulties, involvement in crime and antisocial behaviour[7].

The attachment with siblings and their impact is necessary for a growing child, and missing this link because of relational or community isolation will also add up to their psychological problems[i].

---

[1]) A study by Camacho , 2007

[2]) A study by Dr. Mevlude Akbulut-Yuksel,2009

[3]) A study by Gabriela Guerrero-Serdán, 2009

[4]) Source: A research paper by Anton Parlow, Armed Conflict and Children's Health: The case of Kashmir, 10/31/2012

[5]) A study by Richard Akresh & Leonardo Lucchetti & Harsha Thirumurthy, 2010

[6]) A study conducted under the supervision of Dr. Mushtaq A. Margoob by Dr. Yasir Hassan Rather, Dr. Akash Yousuf Khan, Dr. Gurbinder Pal Singh , Dr. Yasir A. Malik , Dr. Muhammad Mudasir Firdosi and , Dr. Shiekh Ajaz Ahmad , 2006

[7]) Study by Michael Rutter, Sandberg et al, 1992

For most children, the family is the context within which initial relationships and understandings are developed. Very young children are more likely than adolescence to have higher rates of juvenile offending, substance use and mental health problems later in life[8].

The relation between culture and behaviour of an individual is very important and gives the position of one's temperament, it is obvious that personality formation consists mostly of the internalization of the elements of a culture[9].

Personality is the key factor in defining individual uniqueness and shaping an individual's course through life. Culture is the way of life. Culture is not only our conscious values, but also it's our assumptions about the way things are. Humans perceive and believe according to their cultural development. Culture represents one of the important factors of the personality modelling. The study of culture and personality seeks to understand the growth and development of personal or social identity as it relates to the surrounding social environment.

The cultural features of a society generate certain distinctive features in the children's socialization. By using some common socializing elements and mechanisms, there may be formed common features of personality or a configuration of personality features typical for the members of a society. Within each society, there are one or several types of personality that the children have to copy.

The relation between culture and personality is obvious, while the personality forming marshes mostly in the internalisation of the elements of a culture. In a stable and integrated culture, the personality is an individual aspect of the culture, and the culture is a collective aspect of the personality. In each society, the dominant culture coexists with a certain number of subcultures and countercultures. The socialization made within a subculture adds specific elements to the modal personality features. Thus, there appear differentiated personalities in relation to the subcultures (these latter being constituted on ethnical, social class, religious and occupational criteria).

Cultural psychologists have noted that some aspects of personality differ across cultural groups. For example, Americans and Asians have slightly different conceptions of self. American culture promotes a view of the self as independent. American children tend to describe themselves in terms of personal attributes, values, and achievements and they learn to be self-reliant, to compete with others, and to value their uniqueness.

Many Asian cultures, such as those of Japan and China, promote a view of the self as interdependent. Children from these cultures tend to describe themselves in terms of which groups they belong to. They learn to rely on others, to be modest about achievements, and to fit into groups.

Starting in infancy, we learn how to be human through interactions with other people in our culture. Without social interaction, love, modelling and communication with others, a child does not become a normal social creature because it does not adequately develop language, or emotional expressiveness, or expected social responsiveness, or personality.

Culture cannot be separated from personality; culture mediates all thought. Human experiences and social interactions form personality marked by thought, communication, actions, customs, beliefs, values and institutions of a racial, ethnic, religious, and social group type.

---

[8]) Study by DM Ferguson, MT Lynskey,1998.

[9]) Study by DL Horton, CB Mills, 1984.

Personal identity is deeply tied to cultural identity. We often believe we are destined to be like our parents, grandparents, and great-grandparents; to a great extent we are like them and their culture. Whether we are aware of it or not, we are the carriers of our cultural heritage that forms an essential part of our personal identity. It is possible, but difficult to change our understanding of our culture, but it is not possible to totally separate our personal identity from our culture. How we judge another person is a product in part of how well the individual lives up to the cultural values we ourselves have learned from our parents, teachers, and the others of significance around us.

Personality is shaped by both genetic and environmental influences. Among the most important of the latter are cultural influences. Culture is transmitted through language and the modeling of behaviour when conditions permit humans to communicate through shared language, by living in the same historic period, and when they are sufficiently proximal to influence each other. Ecology, among other factors, shapes the culture, which in turn shapes the socialization patterns, which shape some of the variance of personality. Broad empirical support for such a model does exist. In addition to these factors, we consider other constructs that are needed for a better understanding of the way culture influences personality.

Parents ensure that their children are satisfied with the physical and affective needs. Deprived of affection, the children are abnormally developed and they reach a level of asocial or antisocial behaviour. The symptoms of care pointed are de-individualization; an individual loses or dwindle the power of his thoughts and action and becomes dependent on the institution. The second symptom mentioned by the author is acculturation, where the individual gets the institutional values and attitudes which differ from his previous culture. The third symptom is the psychological or physical damage [ii].

Children of war often show symptoms of severe psychological trauma, sleeping disorders, and problem of their concentration, nightmares, withdrawal, aggression, fear of unexpected souls and movements, clinging behaviour, depression, inability to form close relation, bed-wetting, mal-digesting problems and so on. These symptoms affect the way they relate to the world around them. In comparison of behavioural and emotional disorders among primary school-going orphans and non-orphans in Uganda. They show that emotional, behavioural as well as psychiatric disorders occur in these orphan children. In their study, they recommended that counselling and psychology should be taught to the caretakers and teachers of children living in orphanages, and they clearly pointed out the psycho-socio problems with children who have lost their parents. At the age when they need much support from their parents and siblings to cope up with physical and emotional development, the loss of their parents make them more prone to psychological disorders. The attachment with the siblings and their impact is necessary for a growing child, and missing this link because of orphanages will also add up to their psychological problems.[10]

In another study on Kashmir, a sample size comprising 230 children below the age of 18 with 160 males and 70 females [iii]. It was observed that the marriage of the young women took place early. Lack of educational facilities, peer relations, and psychosocial problems and threats of sexual violence from the local community as well as migrants made these young women vulnerable. Schools have not provided the emotional support often needed to these children[11]. Most adopting parents lack information on the problems faced by these children and are therefore unable to offer emotional support; and schoolteachers do not know how to identify psychological and social problems and thus fail to offer individual and group attention. The idea is to show the relation between the environment and the individuals, assessment of their ability to deal with it and to adjust their behaviour. Most children without parental support risk powerful cumulative and often negative effects because of their parents' death, thus becoming vulnerable and predisposed to physical and psychological risks.

---

[10]) Study by Musisi et al,2008.

[11]) A study by Sengendo and Nambi 2004.

In one of the research design, 'quantitative methodology' was realised by researchers to obtain a holistic insight, the 57 degree technique survey was applied . The survey was carried out in different parts of Kashmir by using interview schedule which targeted orphan children in institutional care. An interview schedule was administered and the respondents were asked the relevant questions. The questions were asked in simple and easy-to-understand language considering that the respondents were young kids. The answers were immediately marked on the interview schedule. This was done so that no details escape the mind[12].

The MSF survey revealed that the respondents who were asked to state three important effects they perceived violence to have on children in the communities (Table 3, Appendix V). Over 1,500 answers were obtained (n=1,521). A small minority (2.4%, 37) said there were no problems. The others saw fear as the major effect (24.6%, 374). School-related problems scored highly, including being unable to attend school (15.5%, 236) and having problems with studying, because of a lack of school materials or the absence of qualified teachers (16.3%, 248); schools have difficulty to find staff as nobody wants to work in a conflict area.

Behavioural changes amongst children that were noted included isolation, aggression, drug abuse, lack of respect for elders, loss of morality/values, and hopelessness[13].

Save The Children conducted a survey in 2010 and brought out a paper titled "Orphaned In Kashmir : The State of Orphans in Jammu and Kashmir" this study was conducted in orphanages of district of Anantnag , Baramullah, Kupwara, Poonch and Rajouri , the study revealed that 90 % of orphanages provide quality food , 87 % orphanages were giving good clothing facilities only 67 % having adequate staff . At social and recreational services front this was 100% in Baramullah with regard to health services in orphanages 70 % in Anantnag but Kupwara, Poonch and Rajouri were lagging behind. So far as legal support service availability is concerned as per the report of save the children it was 62 % in Anantnag , 62 % in Poonch , however, in Kupwara the response was very satisfactory than other districts of the state , similarly funds , technical expertise , human power to impart awareness was higher in Kupwara(16%) followed by Rajouri(7%) , Anantnag(4%) and Poonch (3%). In Education , Health , Psycho-social support and Integration was not as per the study up to the mark , besides in child rights and legal protection in other spheres of the life of orphans .

Civil war in north Rwanda and the crop failure in south Rwanda Children born between 1987 and 1991 are shorter because of these two external shocks .[14]And that children in rural Burundi are shorter because of the civil war.[15]

The role of stress, land mine explosions in Colombia between 1998 and 2003 led to lower birth weights and more prematurely births.[16] An example for the impacts of violence on human capital outcomes can be found in the estimation , in the long-run effects on adult earnings of the

---

[12]) Quantitative research approach adopted by Naqshbandi et al.

[13]) Medecins Sans Frontieres(MSF) , Kashmir: violence and health, November 2006, p 16

[14]) A study by R Akresh, P Verwimp, 2006

[15]) Bundervoet, Verwimp and Akresh,2009

[16]) Study by Adriana Camacho, 2007

"Shining Path"-violence in Peru (1980 to 1995).[17] The groups who were in uterus, infants or those of pre-school age during the violence.[18] As adults, these individuals earn less in their jobs.

Although literature on the effects of the Kashmir, militancy and security forces in particular, however, is limited. Moreover, official Census reports.[19] And those based on the National Family Health Survey (NFHS) draw a positive picture for the entire state of Jammu and Kashmir in terms of mortality rates, fertility and vaccination programs. This positive picture potentially masks important district or regional variations, making the methodology and results presented helpful in understanding the impact of the armed violence on children's health[20].

The start of another phase of militancy in Kashmir 1989, India responded to it, by sending in tens of thousands of security force personnel into the valley of Kashmir in January 1990[iv]. This marked the official beginning of the armed violence. Within a short period of time, India stationed a few hundred thousand security force personnel throughout the valley, with a focus on major cities. Violence committed against civilians by militants, as well as security forces inexperienced and overwhelmed infighting militancy [v] were the norm early in the 1990's. [21] Furthermore, thousands of Kashmiri Pandits[vii] migrated from the valley of Kashmir in 1990. [22] By late 1991, the militancy after independence outlook started giving a position of pro-Pakistan movement with new militant groups organizing the uprising[viii] .Violence to the large extent has died out slowly throughout cities in the valley. In 2001-2002, there was another peak in violence as the groups behind the militancy changed again. Their agenda was fighting a "Jihad" against India in committing militant acts, not just in J&K.[23] The various phases of the violence and the regional variation in its intensity allow for an opportunity to identify effects of the conflict on groups differently affected by the violence.

On a novel event-dataset constructed from an in-depth literature review of the violence and crime data, one can easily identify districts more affected by violence, as well as three distinct phases of the violence.[24] Table 1 [see appendix III] presents the count of violent events by time and region. Figure 1 [see appendix III] shows the districts of J&K. The state of Jammu and Kashmir has three regions: Jammu, Kashmir and the sparsely populated Ladakh region. The militancy was concentrated in the Jammu and Kashmir region only. The Jammu region itself includes six districts (Jammu, Doda, Udhampur, Kathua, Rajouri and Poonch). The Kashmir region, also known as the valley of Kashmir, also includes six districts (Anantnag, Pulwama, Srinagar, Badgam, Baramula and Kupwara).[25]

The first phase of the violence can be marked from 1990 - 1996. Militancy focused on urban areas of Kashmir, especially the Srinagar district and the summer capital Srinagar city. To a lesser extent, the winter capital Jammu city in the Jammu region was also affected by violence (Table 1 [see appendix III]). Local government and its agencies [who as per separatists is State and men affiliated to it, collaborate with Indian establishment to weaken ongoing the resistance movement] , which are targets for militants in general are present in the capitals.[26] The second phase was from 1996 to 2001 with a peak in violence around 2001. Militancy concentration moved away from Srinagar (city) to the smaller cities of Kashmir and to the districts of Jammu (Doda, Rajouri and Poonch) located closer to the Line of Control (LoC). This was because of the massive presence of security force personnel in the urban areas of Kashmir. The LoC also separates India from Pakistan and most militant infiltration originated there. During the 2000-2001 peak in violence, Hindus [Non-Muslims] were specially targeted [ix] through multiple massacres and staged encounters.[27] Before these massacres, most civilian victims were Muslims. The third phase started after the peak in violence in 2001 and can be de-scribed as a low-intensity conflict with no major incidences against civilians in Jammu and Kashmir. In some sense the population got used to the presence of a massive amount of security force personnel (up to 0.75 million) and the fear of violence. Most victims of the violence were actually militants during this period. As per National Family Health Survey (NFHS) for India, a national and representative household survey, to analyze the effects of the Kashmir violence on children's height. The NFHS has three individual rounds: NFHS-1 (1993), NFHS-2 (1998-1999) [see appendix III] and NFHS-3 (2005-2006). Women who were ever-married and aged 15 to 49 years were interviewed. Information on their demographic, household and health background (mainly utilization of health services) were collected. Their children, ages 59 months (NFHS-1, NFSH-3) as shown in appendix III and 36 months (NFHS-2), were measured in terms of height and weight. The three survey rounds for Jammu and Kashmir cover different phases of the violence, with different districts covered in each because of security reasons. The NFHS-1 [see appendix III] was only conducted in the Jammu region. The NFHS-2 [see appendix III] covers the entire Kashmir valley and three out of six districts in Jammu. The NFHS-3 [see appendix III] covers the entire Jammu and Kashmir region. The coverage across survey rounds is sufficient to identify children exposed differently by the violence in uterus and early in life[28].

---

[17]) A study by Jose Galdo,2010

[18]) ibid

[19]) Census of India 2001, 2011.

[20]) Source: A research paper by Anton Parlow, Armed Conflict and Children's Health: The case of Kashmir, 10/31/2012)

[21]) Study by Joshi 1999, and Schofield 2001.

[22]) Source: Asia Watch 1993

[23]) Meyerle Gerald "Deaths by a thousand cuts: The Dynamics of Protracted Insurgency in Kashmir and Sri Lanka", Ph.D. Thesis, 2008.

[24]) INSCR 2012

[25]) On 6th July, 2006, Thursday, Jammu and Kashmir was reorganised into 22 districts. The NFHS surveys are on the old district structure.

To summarize basic descriptive statistics for each NFHS survey round. Height for age z-scores for children is computed according to the WHO 2006 growth standards. Children in J&K are shorter on the average and close to being stunted[x]. The samples of children are n=666 (NFHS-1) , n=962 (NFHS-2) and n=1226 (NFHS-3) [see appendix III].

The urban-rural differential in children's height is typical for developing countries where health services are more available in urban areas. In rural areas mothers have less access to health services during and after pregnancy. These health services can include checkups, access to doctors and micro-nutrients needed for the development of the child. Access to health services deteriorated during the 1990's in rural Kashmir. Basic health services could not be delivered to rural areas because of the violence, which can explain the decrease in HAZ scores for the NFHS-2 [see appendix III] round.[29]

Additionally, the developments in height scores described above can be visualized using kernel weighted local polynomial graphs. In developing countries younger children can have lower HAZ-scores [xi] than older children because of improvements in health services over time if the development process is not interrupted.[30] To conserve space, only shown are urban-rural differentials for the NFHS-1 and Kashmir-Jammu differentials for the NFHS-2 and 3 (Figure 5) [see appendix III].

---

[26]) Studies by SN Kalyvas 2006, PatriciaJustino, 2009

[27]) Source: SATP, 2012.

[28]) Source: A research paper by Anton Parlow, Armed Conflict and Children's Health: The case of Kashmir, 10/31/2012)

[29]) Asia Watch,1993

[30]) WHO 2012

The NFHS-1 [see appendix III] only includes the Jammu region. Children in urban areas have slightly lower HAZ-scores than children in rural areas, which could be attributed to the insurgency. Children in Kashmir are shorter than children in Jammu using the NFHS-2 sample. Furthermore, the older cohort has slightly better scores that fall sharply. The trend for the NFHS-3 is mixed. Younger children in Jammu (up to 24 months) got severely affected by the violence in Kashmir, one reason could be that Hindus became targets during 2001-2002. Hindus are concentrated in the Jammu region of the state. This is because almost the entire Hindu community left the valley after of the outbreak of the militancy in 1990[31].In Kashmir violence remained ceaselessly going on. Then curfews, crackdowns , unnecessary searches , inhuman treatment given to youth, young, old and women, in presence of all(family and children)—these cannot be overlooked or underestimated . No doubt Kashmiri Pandits did suffer , but in Jammu they felt safer and enjoyed innumerable concessions as well.

Health of children, defined as height for age z-scores (HAZ), is negatively affected by the violence in Jammu and Kashmir. The Kashmir armed violence had three phases, which allow identifying a series of treatment and control groups of children across space and time. Children, who experienced violence in uterus and early in their life, are 0.9 to 1.4 standard deviations shorter than children who experienced less or no violence early in their life. The magnitude is similar to results found in the literature for stronger forms of armed conflicts, such as wars. The Kashmir militancy differs from these stronger forms of conflict because fewer civilians were killed, fewer infrastructures was destroyed, and mass dislocation, which is typical for stronger forms of armed conflict. Most of the exposure of violence can be best described as a constant fear of militant acts/ security forces raids/ torture and mainly harassment by security force personnel stationed across Kashmir. Nevertheless, this constant stress caused a similar impact on height of children compared to more violent forms of conflict. The results of the paper suggest that it is possible to identify groups more affected in their human capital development than others during armed conflicts. Development programs, including those administered through non-governmental organisations could be specially designed to target these groups and help ameliorate the negative effect of an armed conflict on future human capital accumulation.

Indian government that allocates resources to fight militancy and to restore order cannot also fund development projects (health and literacy programs) for the least developed states in their nations. The long-term consequences for the entire region are difficult to quantify. For instance, health services (vaccinations and checkups during pregnancy), typically having positive effects, have no significant effects on height scores of children, and not just for the children affected by the violence most. This could be seen as indirect costs of the violence.

The studies on armed conflicts mostly focused on groups more affected by violence and compared their human capital outcomes (education and health) with groups less affected by violence, but indirect effects have yet to be quantified. In the context of the Kashmir armed violence, the research could estimate these effects using the three survey rounds of the National Family Health Survey (NFHS) and compare health outcomes across rounds[32].

Objectives:

- To understand the circumstances for being an orphan in Kashmir.

---

[31]) Source: A research paper by Anton Parlow, Armed Conflict and Children's Health: The case of Kashmir, 10/31/2012.

[32]) ibid.

- To assess the psychological impact on orphans in institutions/orphanages/society.
- To assess orphans' viewpoint regarding their future in a conventional society.
- To arrive for the structured policy for state / hostels/orphanages.

Design Overview

A large-scale culture of war is today a reality, and it links particular war zones to foreign media, development and business groups, power brokers, arms suppliers, soldiers, militants or armed volunteers and strategists. As these many groups interact, and local and transnational concerns are enmeshed, ideas and values about what constitutes 'acceptable' warfare practices are constructed and reshaped. Indeed, specialists in war studies have pointed out to the distinctive character of most contemporary armed conflicts, and to the qualitative shift in the nature and conduct of warfare. Today's conflicts are often fought by multiple, semi-autonomous armed groups within existing state boundaries. They are protracted, lasting years if not decades, and they make defenceless civilians - especially children and women - particularly vulnerable.[33]

At the heart of the growing phenomenon of mass violence and social disintegration is a crisis of normative and value systems. Deficient as our grasp of the extent of the problem is, even less is known about what kinds of cultural norms and values about on orphans, and how these are undermined or shattered by the armed conflict . The absence or non-observance of normative frameworks and value systems can give rise to an 'ethical vacuum' - a setting in which international standards are ignored with impunity and where normative and value systems have lost their sway. There is a need to identify norms and values that could lead to the prevention of armed violence and the protection of orphans caught up in it. The most damaging loss a society can suffer is the collapse of its value system. Values matter, even in time of armed conflict. On the other hand, it is also important to investigate value and normative systems related to notions of childhood and child protection in times of armed conflict, especially orphans. What does it mean to be a child/orphan? How do societies understand the issue of child protection? What kinds of signifiers are attached to family life and parent-child relationships, especially in times of armed conflict? How do societies perceive political violence and their effect on children? How are these boundaries enforced or maintained in times of violent conflict? What changes are effected in armed violence that render children/orphans vulnerable?

The propagation of international norms for the protection of children/orphans in times of armed conflict has also been hindered by insufficient information and knowledge on the part of international policymakers of those local norms and values within societies which have protected children from harm, especially orphans. To the extent that the erosion of these value systems may have partially enabled the victimization of children in the first place, their revival or strengthening could provide strong local bases for the protection of children/orphans. Equally significantly, these normative values could provide essential reference points for the propagation of international norms, not just among international actors and activists but also among communities and within societies. It is critical, therefore, to know where such knowledge exists or may have existed, and where it has survived or changed.

A wider challenge is to assess how local cultural norms and values may intersect with broader political, economic and other forces in ways that could lead not just to the protection of children/orphans during armed conflict, but could sometimes even cause them harm. Without a deeper and more nuanced understanding of local dynamics, the capacities of international and local actors to prevent the negative impact of armed conflict on children/orphans , to protect them once they have become affected, and even to re-integrate them in post-conflict situations, will be limited. In this context, it is also critical to understand the role that children themselves can play in activities designed to assist them. Children are often active agents in processes that influence their lives and not merely passive members of "target groups" that are acted upon by others.

---

[33]) Source: http://mofa.go.jp/policy/human/child/survey//annex2.html#8

Participants in this research attempted to synthesize existing knowledge on conflicts that have been especially devastating for orphans whose parent/s died of the armed violence , so our research associates tried to accentuate upon several sub-themes identified in this broad research area. One of them is direct collection of information that could lead to the identification of cultural norms and values concerning the protection of orphans. Another sub-theme, much broader is the issue of what constitutes childhood (youth, adolescence, teenage) and how it is different from adulthood (manhood, womanhood). What kinds of normative models and meaning systems are attached to the notions of children and childhood? How are the relationships between adults and children (within the family, at school, at the orphanage and in society in general) perceived and articulated? What processes exist to establish the transition from childhood into adulthood? What are the social expectations of society vis-à-vis orphan?

A critical comparison of different studies vis-à-vis orphans has been already considered, the threadbare discussions and deliberations were called with the research associates and a team of 7 members was constituted for the collection of data and identification of orphans in various welfare institutions, especially from Anantnag district used for the baseline research. This randomised, multicentre comparison was conducted in different range of groups among orphans, the protocol was kowtow to the set of rules as a part of applied psychology.

Key Words :

- Post-traumatic Stress Disorder (PTSD)
- Major Depression Disorder or Clinical Depression (MDD)
- Conversion Disorder(CD)
- Panic Disorder (PD)
- Attention Deficit Hyperactivity Disorder (ADHD or ADHAD)
- Female Hysteria(Hysteria)
- Paranoid Personality Disorder (PPD)
- Schizotypal Personality Disorder (SPD)
- Antisocial Personality Disorders(APD)
- Reactive Attachment Disorder (RAD)
- Dysthymia
- Eating disorders
- Ablutophobia- Fear of washing or bathing.(ABL)
- Entomophobia- Fear of insects. (ENT)
- Achluophobia- Fear of darkness. (ACH)
- Acousticophobia- Fear of noise .(ACU)
- Acrophobia- Fear of heights. (ACR)
- Aerophobia- Fear of drafts, air swallowing, or airborne noxious substances. (ARP)
- Aeroacrophobia- Fear of open high places (AER)
- Agoraphobia- Fear of open spaces or of being in crowded (AGO)
- Ailurophobia-Fear of cats.(AIL)
- Altophobia- Fear of heights (ALT)

- Ancraophobia- Fear of wind(Anemophobia) (ANC)
- Atephobia- Fear of ruin or ruins. (ATE)
- Claustrophobia- Fear of confined spaces(CLAU)
- Clithrophobia or Cleithrophobia- Fear of being enclosed. (CLITH)
- Coimetrophobia- Fear of cemeteries (COIM)
- Enochlophobia- Fear of crowds. (ENOCH)
- Spectrophobia – Fear of ghosts (GP)
- Laliophobia or Lalophobia- Fear of speaking.(LALI),
- Politicophobia- Fear or abnormal dislike of politicians. (POLITI),
- Sciophobia Sciaphobia- Fear of shadows. (SCIOP)
- Intelligence Quotient (IQ)
- 70-84= Borderline (BL),
- 85-109= Average (AV),
- 110-119= Bright Normal (BN)
- 120-129=Superior (SP),
- <130= Very Superior(VS)

Setting and Participation

Frequent visits were paid to several orphanages of Kashmir and data collected using interview schedule, mainly using questionnaire. The target group and respondents were orphans of Kashmir along with wardens of orphanages, officers of Social Welfare Department, besides orphan boys and girls either living with their families or community were also approached by the members of our team, who were assigned the particular job. In some cases psychiatric views were sought and even professional psychologists were consulted for the mode of study. The identified orphans were segregated in the category of Natural Orphans and Orphans of Armed Conflict

Natural Orphans Total in No. 720

[Those orphans whose parents mainly fathers have died naturally]

0-5 Age Group

n=60 males n=34 females n= 26

6-14 Age Group

n=355/ Males n=189/ Females n=166

15-18 Age Group

n=277 Male n=164 Female n=113

19-25 Age Group

n=28 Male n=13 Female n= 15

Orphans of Armed Conflicts Total in No. 442

[Orphans whose parents mainly fathers have died of armed violence in Kashmir]

0-5 Age Group

n = 22 Male n= 12 Female n=10

6-14 Age Group

n=285 Male n= 124 , Female n=161

15-18 Age Group

n=97 Male n= 50 , Female n=47

Orphans of Armed Conflict

19-25 Age Group

n=38 Male n=21 Female n=17 out of 442

Statistical Analysis

Two groups have been formulated, first Natural Orphans [Whose Parents mainly father has died of natural death] in this category 720 orphans have been identified included in the study , second group is Orphans of Armed Conflict [Whose father has died of armed violence] .A total of 442 have been identified and taken for the study , but all the orphans in the study are mainly from Anantnag.

Natural Orphans

0-5 Age group

n=60 males n=34 females n= 26 out of 720

Stress Disorders: ADHD is found in 2 males n= 34 / 5.88%/ females 3 n= 26 11.54%/ total in the range 5 n=60/8.33%.

RAD is found in 1 male n=34/ 2.94% / female 1 / n=26 / 3.85%. The total in the range 2 n=60/ 3.33% (**See Figure 1)**

Phobias : ABL is found in 2 males n=34 / 5.88% / females 1 n=26/ 3.85%/ total in the range 3 n=60 / 5.0%

ENT is found in 3 males n=34/ 8.82%/ females 5 n=26/ 19.23%. Total in the range 8/ n=60/ 13.33%.

ACH is found in 2 males/ n=34/ 5.88% / females 3 ,n=26/ 11.54%/ .Total in the range 5 n=60/ 8.33%.

ARP is found 2 males n=34/ 5.88%/ females 3 n=26 / 11.54%/ total in the range 5 n=60/ 8.33%.

AER in male is 1/ n=34/ 2.94%/ females 1 / n=26/ 3.85%/ total in the range 2 n=60/ 3.33%

AIL is found in 5 males n=34/ 14.71%/ females 5 n=26/ 19.23% / total in the range 10 n=60/ 16.67%.

LALI is found in 3 males n=34/ 8.82%/ female 1 n=26/ 3.85% / total in the range 4 n=60/ 6.67%

SCIOP is found in 1 male n=34/ 2.94%/ female 2/ n=26/ 7.69% / total in the range 3/ n=60/ 5.0%. **(See Figure 2)**

Figure 1

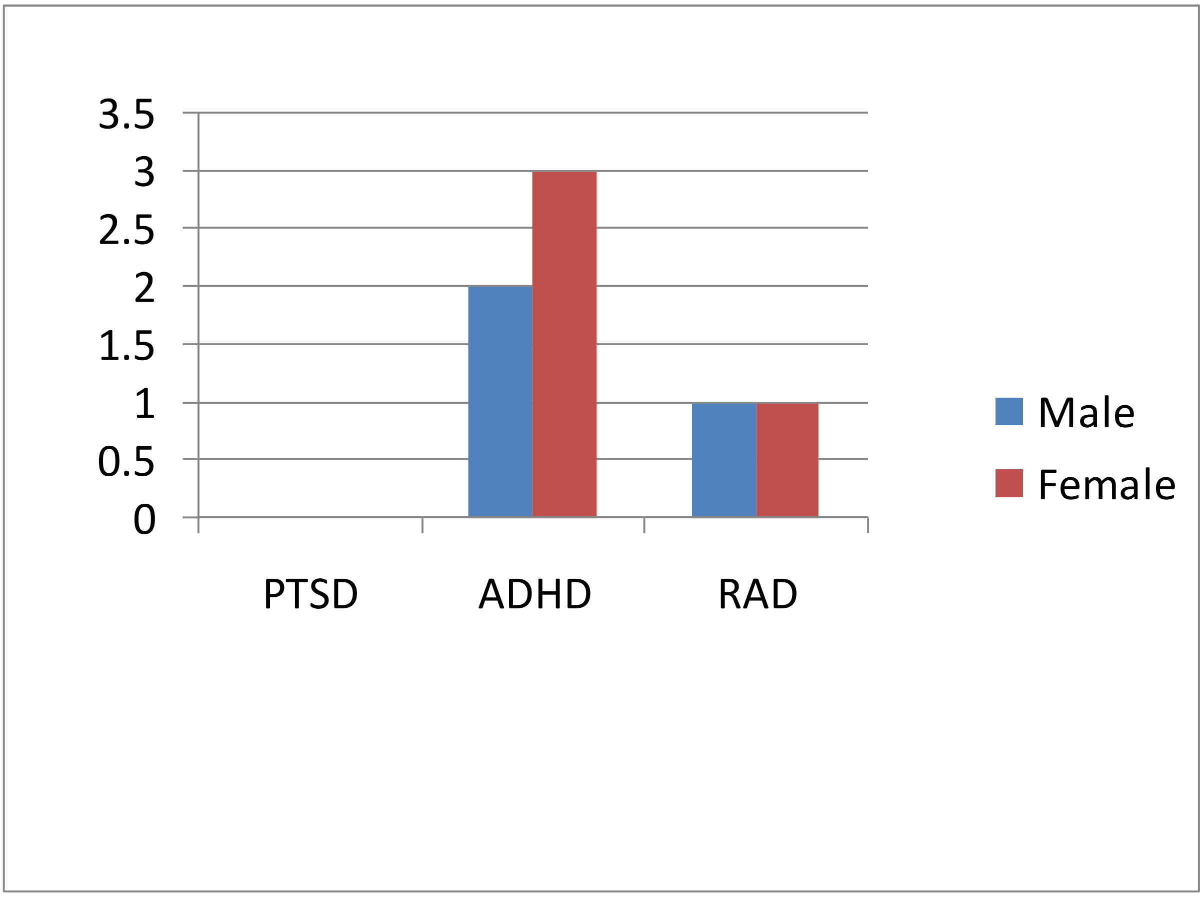
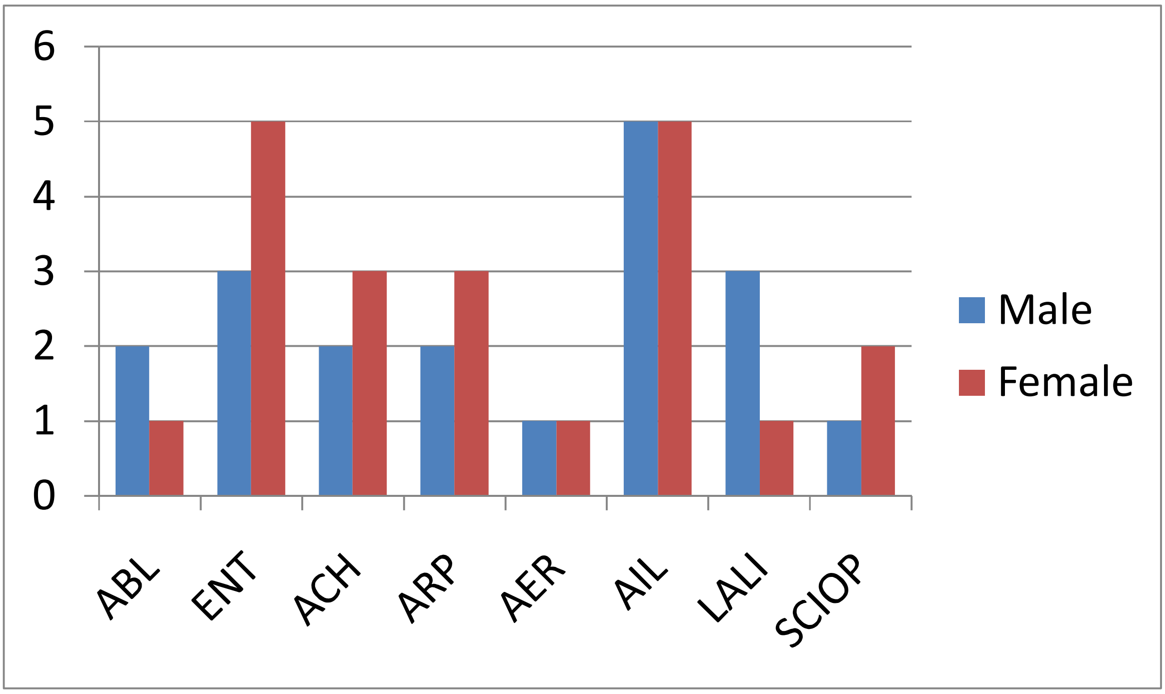


Figure 2



Natural Orphans

6-14 Age Group out of 720 (see Figure 3)

n=355/ Males n=189/ Females n=166

Stress Disorders: PTSD is found in 49 males n=189/ 25.92%/ in females 60 n=166/ 36.14%/ total in the range 109/ n=355/ 30.70%

MDD is found in 39 males n=189/20.63%/ females 48/ n=166/ 28.92%/ total in the range 89/ n=355/25.07%.

CD is found in 17 males n=189/ 8.99%/ females 29/ n=166/17.47%/ total in the range 46/ n=355/12.96%.

PD is found in 8males n=189/4.23%/ 4.23%/ females 10,n=166/6.02%/ total in the range 18/ n=355 / 5.07%.

ADHD is found 11 males n=189/5.82%/ females 13 ,n=166/7.83%/ total in the range 24,n=355/6.76%.

Female Hysteria is found 10 females n=166/ 0.60%/ total in the range 10,n=355/2.8%.

SPD is found in 9 males / n=189/ 4.76%/ females 11/ n= 166/ 6.63%/ total in the range 20/ n=355/5.63%.

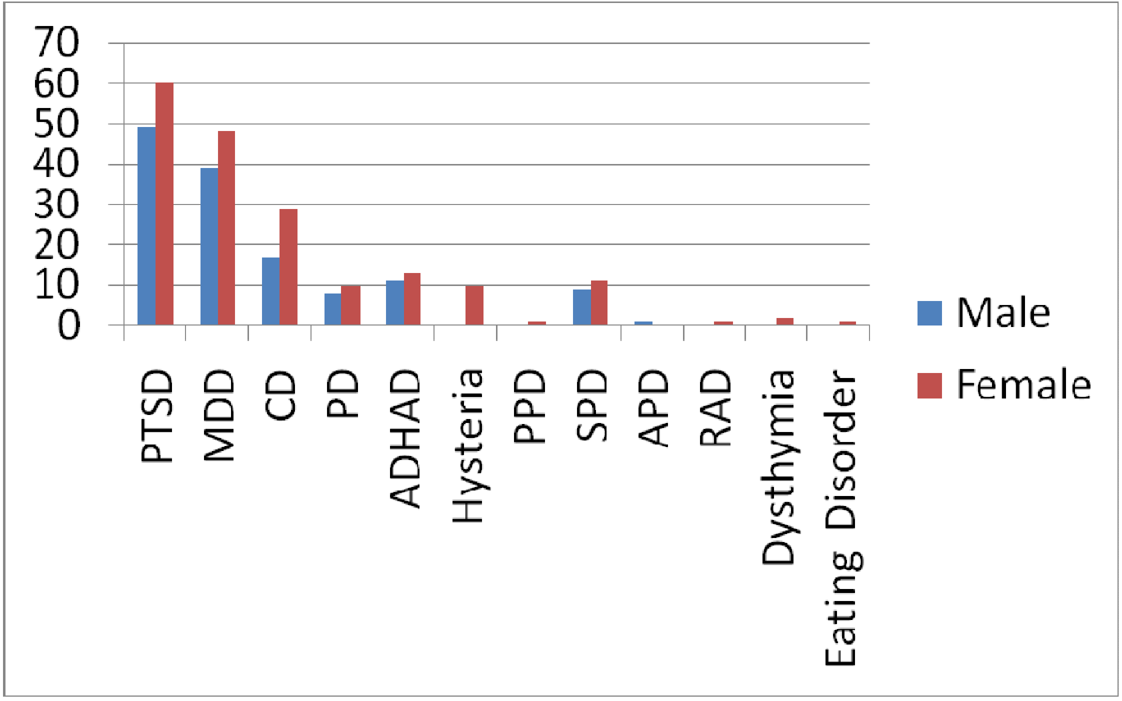
APD is found in 1 male / n=189/0.53%/ total in the range 1/ n=355/ 0.28%.

RAD is found in 1 female/ n=166/ 0.60%/ total in the range 1/ n=355/ 0.28%.

Dysthymia is found in 2 females/ n=166/1.20% total in the range 2 n=355/ 0.56%.

Eating Disorder is found in 1 female n=166/0.60%/ total in the range 1/ n=355/ 0.28%.

Figure 3



Natural Orphans

6-14 Age Group (See Figure 4)

n=355/ Males n=189/ Females n=166 out of 720

Phobias: ABL is found in 4 males n=189/ 2.12%/ females 3, n=166/ 1.81%/ total in the range 7/ n=355/ 1.97%.

ENT is found in 7 males n=189/3.70%/ females n=166/7.23%/ total in the range 19,n=355(5.63%.)

ACH is found in 6 males n=189/3.17%/ females 14,n=166/8.43% in the total range 20,n=355 (5.63%)

ACU is found 2 males n=189(1.06%), females 8,n=166(4.82%), total in the range 10, n=355(2.82%)

ACR is found in 12 males , n=189, (6.35%), females 14, n=166(8.43%) total in the range 26, n=355(7.32%).

ARP is found in 1 male, n=189 (0.53%), females 2, n=166(1.20%) , total in the range 3, n=355(0.85%).

AER is found in 6 males, n=189(3.17%), females 8 , n=166(4.82%), total in the range 14, n=355(3.94%).

AGO is found in 18 males n=189 (9.52%), females 22,n=166(13.25%), total in the range 40 n=355(11.27%).

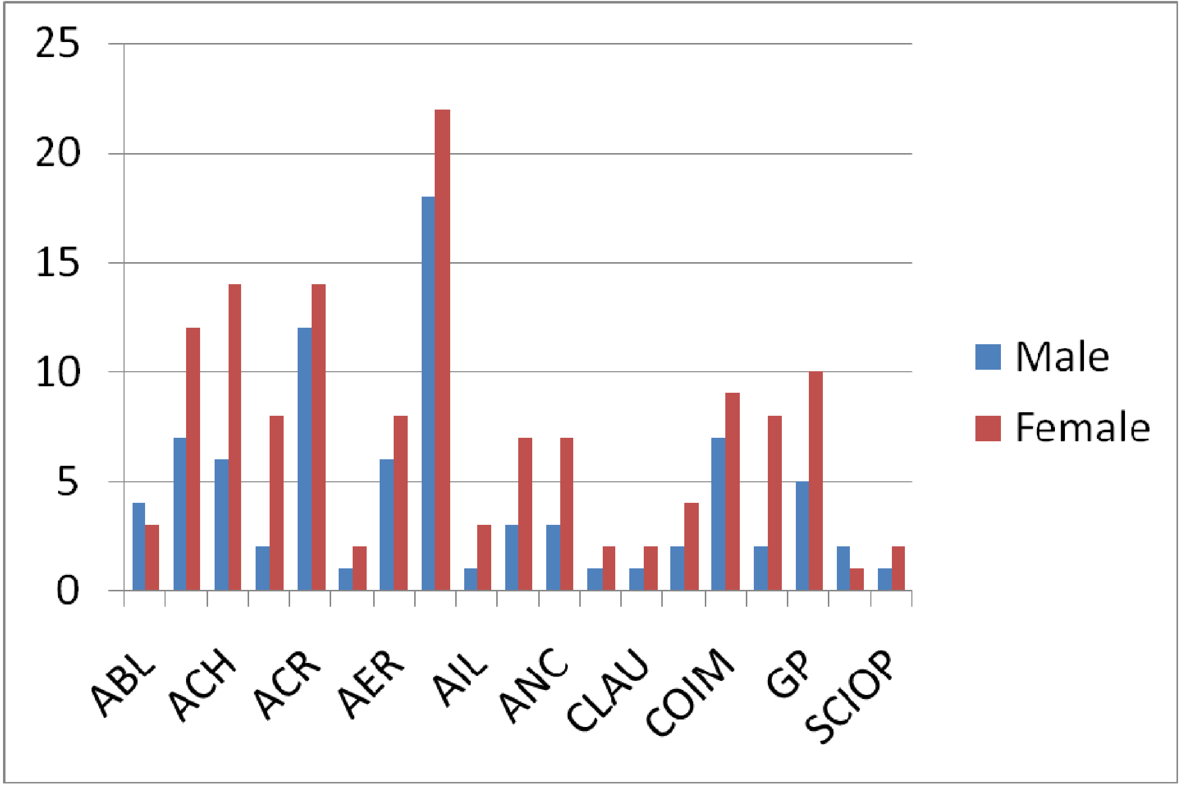
AIL is found in 1 male n=189 (0.53%), females 3 , n=166 (1.81%) total in the range 4 , n= 355 (1.13%).

ALT is found in 3 males , n=189 (1.59%), females 7 , n=166 (4.22%) , total in the range 10, n=355 (2.82%).

ANC is found in 3 males n=189(1.59%), females 7, n=166 (4.22%) total in the range 10, n=355 (2.82%)

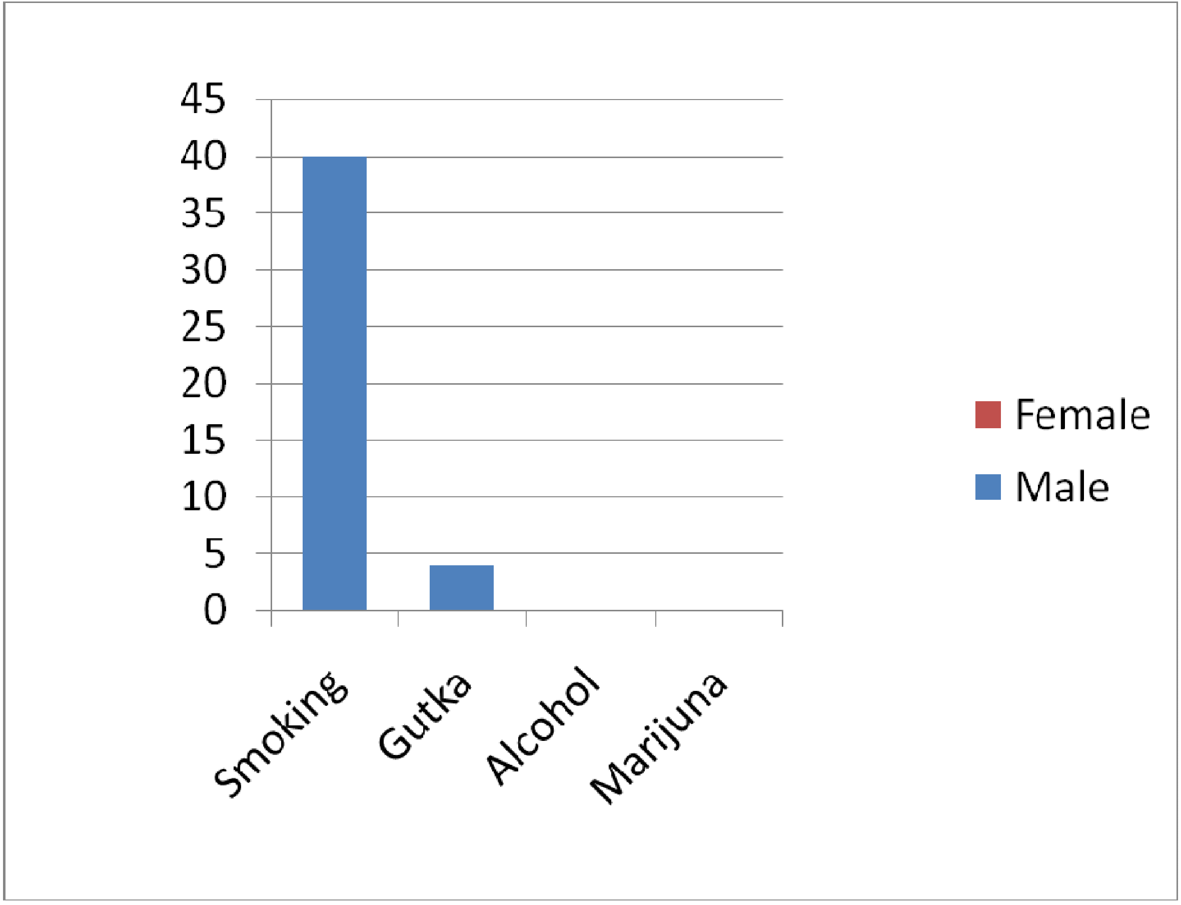
ATE is found in 1 male , n=189 (0.53%) , females 2 , n=166 (1.20%), total in the range 3 , n=355 (0.85%).
CLITH is found in 2 males ,n=189 (1.06%), females 4 , n= 166(2.41%), total in the range 6, n=355(1.69%).
COIM is found in 7 males , n=189(3.70%), females 9, n=166(5.42%), total in the range 16 , n=355 (4.51%)
ENOCH is found in 2 males , n=189 (2.65%) , females 10 , n=166(6.02%) total in the range 15 , n= 355 (4.23%)
LALI is found 2 males n=189 (1.06%) , female 1, n=166 (0.60%), total in the range 3 , n= 355(0.85%).
SCIOP is found in 1 male , n= 166 (1.20%) total females 2, n=166 (1.20%) total in the range 3 , n=355 (0.85%).

Figure 4



Natural Orphans
6-14 Age Group (See Figure 5)
n=355/ Males n=189/ Females n=166 out of 720
Smoking : This habit is found in 40 males ,n=189/ 21.61% total in the range 40 n=355 11.2%.[In the orphans who are in hostels/orphanages , this habit is very low]
Gutka : is taken by 4 males / n=189/ 2.12%/ total in the range 4, n=355/ 1.13%.

Figure 5



Natural Orphans

15-18 Age Group (See Figure 6)

n=277 Male n=164 Female n=113 out of 720

Stress Disorders: PTSD is found in 30 males n= 164 (18.29%,) females 36,n=113(31.85%), total in the range 66, n= 277(23.82%).

MDD is found in 25 males n=164(15.24%), females 24, n= 113(21.23%) , total in the range 49, n= 277 (17.68%).

CD is found in 13 males n=164 (7.93%), females 16 , n= 113 (14.16%), total in the range 29, n= 277(10.47%).

PD is found in 5 males n=164(3.05%), females 7 n=113 (6.19%), total in the range 12, n= 277(4.33%).

ADHD is found in 4 males n=164(2.44%), females 5, n= 113(4.42%), total in the range 9, n= 277 (3.25%).

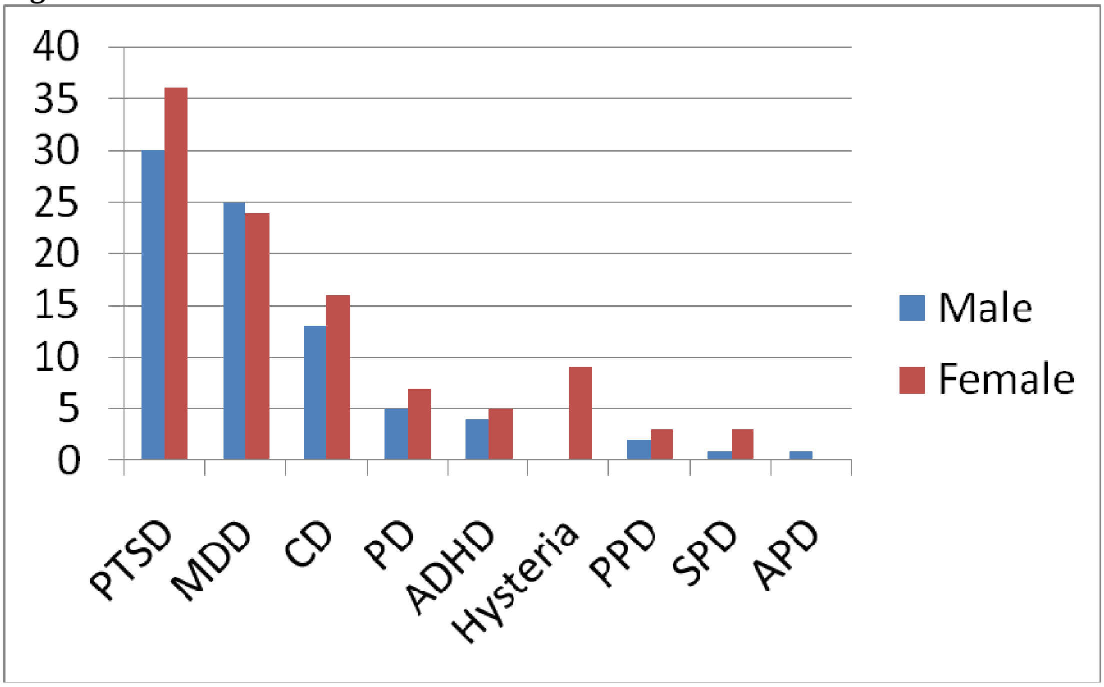
Female Hysteria is found in 9 females , n=113 (7.96%)

PPD is found in 2 males n=164(1.22%), females 3 n=113(2.65%) , total in the range 5 n= 277(1.81%).

SPD is found in 1 male n=164(0.61%) n=164 (0.61%), females 3 n= 113(2.65%), total in the range 4 n= 277(1.44%).

APD is found in 1 male n= 164(0.61%), total in range 1 , n=277, (0.31%).

Figure 6



Natural Orphans

15-18 Age Group

n=277 Male n=164 Female n=113 out of 720 (See Figure 7)

Phobias: ENT is found in 1 male n=164(0.61%), females 9 n=113(7.96%), total in the range 10, n= 277 (3.61%).

ACH is found in 1 male n=164(0.61%), females 10 n= 113 (8.85%), total in the range 11 , n=277 (3.97%).

ACU is found in 3 females n=113 (2.65%) , in the total range 3 , n=277 (1.08%).

ACR is found in 5 males n= 164 (3.04%) , females 10 , n=113 (8.85%), in the total range 15 n=277(5.42%).

ARP is found in 1 female n=113 (0.88%) in the total range 1 , n=277(0.36%).

AER is found in 3 males n=164 (1.83%), females 7 ,n=113 (6.19%), in the total range 10, n=277 (3.61%)

AGO is found in 2 males n= 164 (1.22%) , females 5, n=113 (4.42%) , in the range 7 , n=277 (2.53%).

ALT is found in 1 male , n=164 (0.61%), females 2 , n=113 (1.77%) , in the total range 3 , n=277 (1.08%).

ANC is found in 2 males , n=164 (1.22%), females 5 , n=113 (4.42%) , total in the range 7 , n= 277 (2.53%).

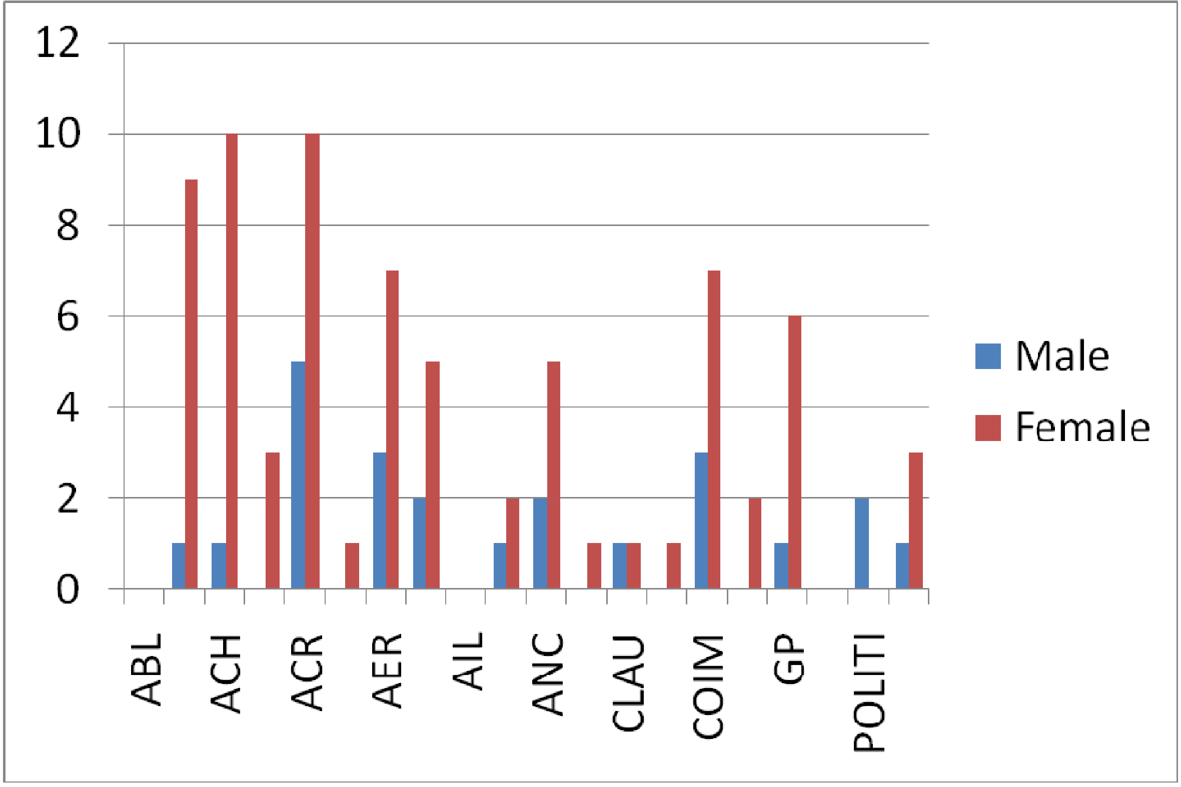
ATE is found in 1 female , n=113 (0.88%), total in the range 1, n=277 (0.36%).

CLAU is found in 1 male , n= 164 (0.61%) , female 1 , n=113 (0.88%), total in the range 2 , n=277(0.72%)

CLITH is found in 1 female , n=113 (0.88%), total in the range 1 , n=277 (0.36%).

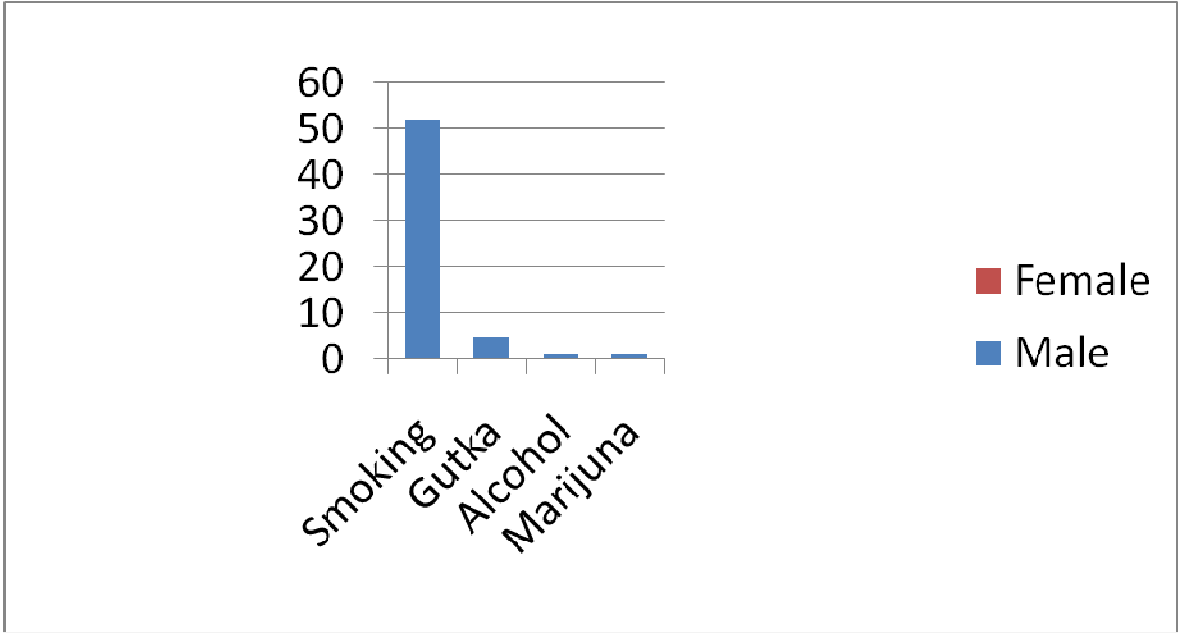
COIM is found in 3 males , n=164 (1.83%), females 7 , n=113(6.19%), total in the range 10 , n= 277(3.61%).
ENOCH is found in 2 females n=113 (1.77%) , total in the range 2 , n= 277(0.72%).
GP is found in 1 male , n= 164 (0.61%), females 6 , n= 113 (5.31%), total in the range 7 , n=277 (2.53%)
PILITI is found in 2 males , n=164 (1.22%), total in the range 2 , n= 277 (0.72%).
SICOP is found in 1 male , n=164 (0.61%), females 3 , n=113 (2.65%), total in the range 4 , n=277 (1.44%).

Figure 7



Natural Orphans
15-18 Age Group
n=277 Male n=164 Female n=113 out of 720 (See Figure 8)
Smoking : 52 males in this category take cigarettes , hubble-bubble[Huka] n=164 (31.71%), total in the range 52 n= 277(18.77%)[17% less among orphans the orphans staying in hostels /orphanages].
Gutka : Males 5, n=164 (3.05%) use Gutka total in the range 5, n= 277(1.81%)
Alcohol :1 male in this category are alcoholic , n=164 (0.61%), total in the range 1 , n=277 (0.36 %)
Marijuna :1 male in this category use cannabis n= 277 (0.61%)

Figure 8



Natural Orphans

19-25 Age Group

n=28 Male n=13 Female n= 15 out of 720 (See Figure 9)

Stress Disorders :PTSD is found 2 male s n=13 (15.38%) females 3 , n=15 (20%) , in the total range 5 , n=28 (17.85%).

MDD is found in 1 male , n=13 (7.69%), females 2 , n= 15 (13.33%), total in the range 3 , n=28(10.71%).

CD is found in 1 male , n=13 (7.69%), females 2, n=15 (13.33%) , total in the range 3, n=28 (10.71%)

PD is found in 1 female , n=15 (6.67%, total in the range 1 , n=28 (4.0 %).

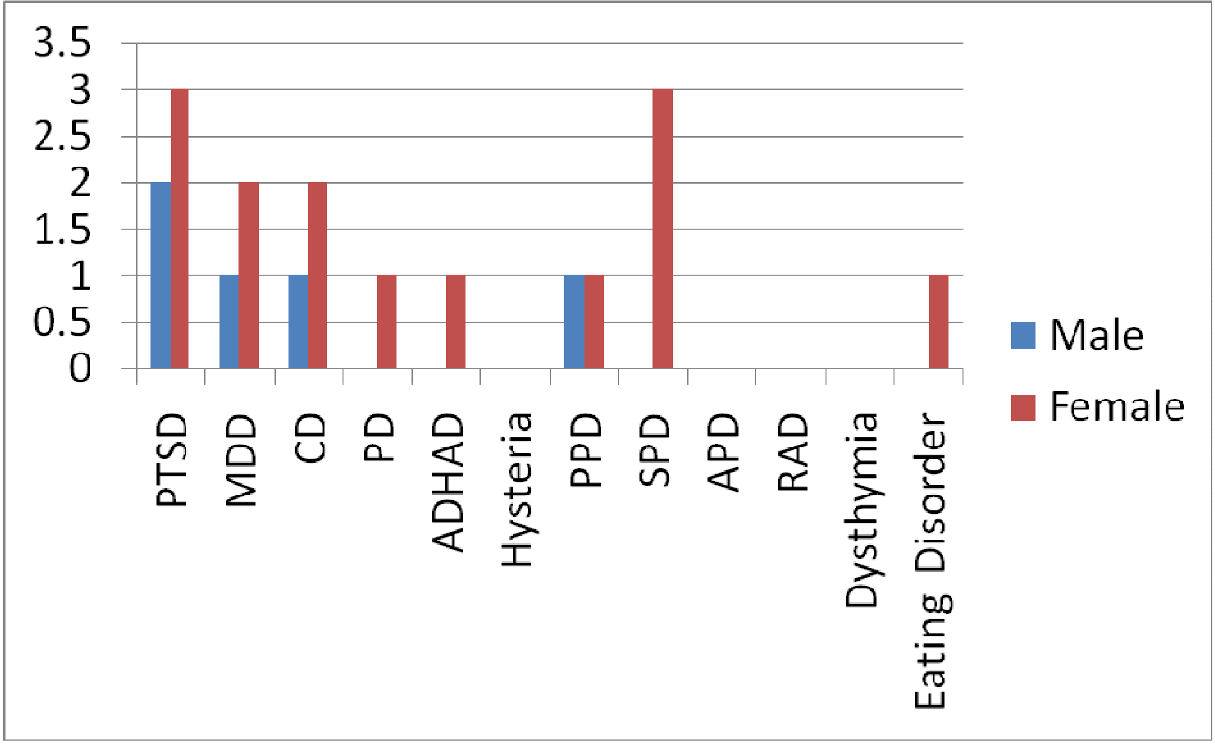
ADHD is found in 1 female , n=15 (6.67%) , total in the range 1 , n=28 (4.0%).

PPD is found in 1 male , n=13 (7.69%), female 1 , n=15 (6.67%), total in the range 2 , n=28 (8.0 %).

SPD is found in 3 females , n=15 (20.00%), in the range 3 , n=28 (12.00%).

Eating Disorder is found in 1 female , n=15 (6.67%), total in the range 1 , n=28 (4.00%).

Figure 9



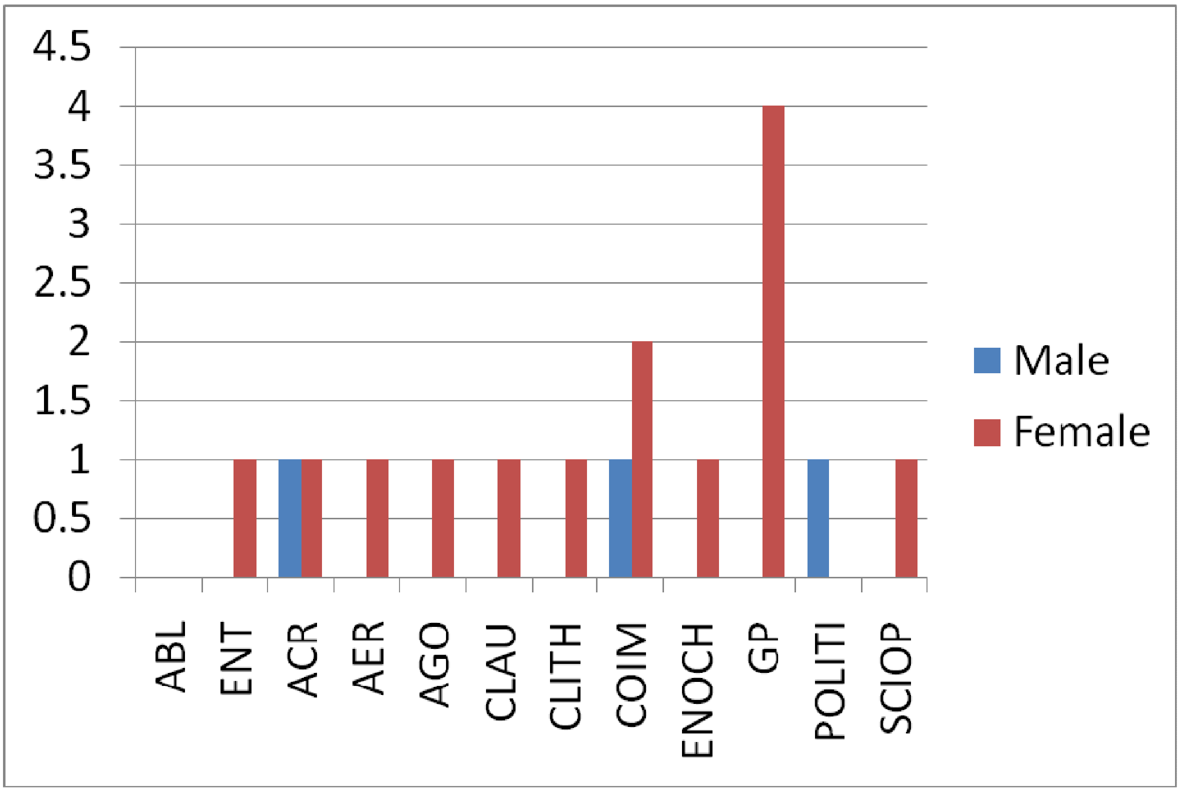
Natural Orphans

19-25 Age Group

n=28 Male n=13 Female n= 15 out of 720 (See Figure 10)

Phobias: ENT is found in 1 female , n=15 (6.67%), total in the range 1 , n=28 (4.00%).
ACR is found in 1 male , n=13 (7.69%) , females 1 , n=15 (6.66), total in the range 3 , n= 28 (7.14%).
AER is found in 1 female , n=15 (6.66%) , total in the range 1 , n= 28 (3.57%)
AGO is found in 1 female n=15 (6.67%), total in the range 1 , n= 28 (4.00%)
ANC is found in 1 female , n=15 (6.67%) , in the total range 1 , n=28 (4.00%)
CLAU is found in 1 female , n=15 (6.67%) , total in the range 1 , n=28 (4.00%).
CLITH is found in 1 female , n=15 (6.67%) , total in the range 1 , n= 28 (4.00%)
COIM is found in 1 male , n=13(7.67%), females 1 , n=15 (13.33%), total in the range 2 , n=28 (7.14%).
ENOCH is found in 1 female , n=15 (6.67%), total in the range 1 , n=28 (4.00%).
GP is found in 4 , females , n=15 (26.67%), total in the range 4 , n=28 (16.00%)
POLITI is found in 1 male , n=13 (7.6%), total in the range 1 , n= 28 (3.5 %).
SCIOP is found in 1 females n= 15 (6.66%) , total in range 1 , n=28 (3.57%).

Figure 10



Natural Orphans

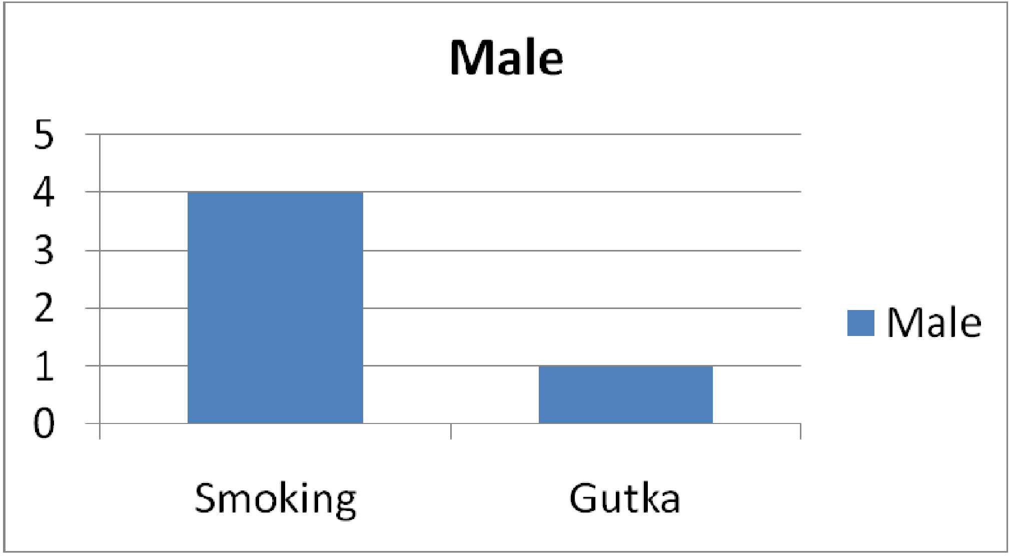
19-25 Age Group

n=28 Male n=13 Female n= 15 out of 720 (See Figure 11)

Smoking :4 males take cigarettes use hubble-bubble for tobacco intake , n=13 (30.77%), total in the range 4 , n= 28 (16%).

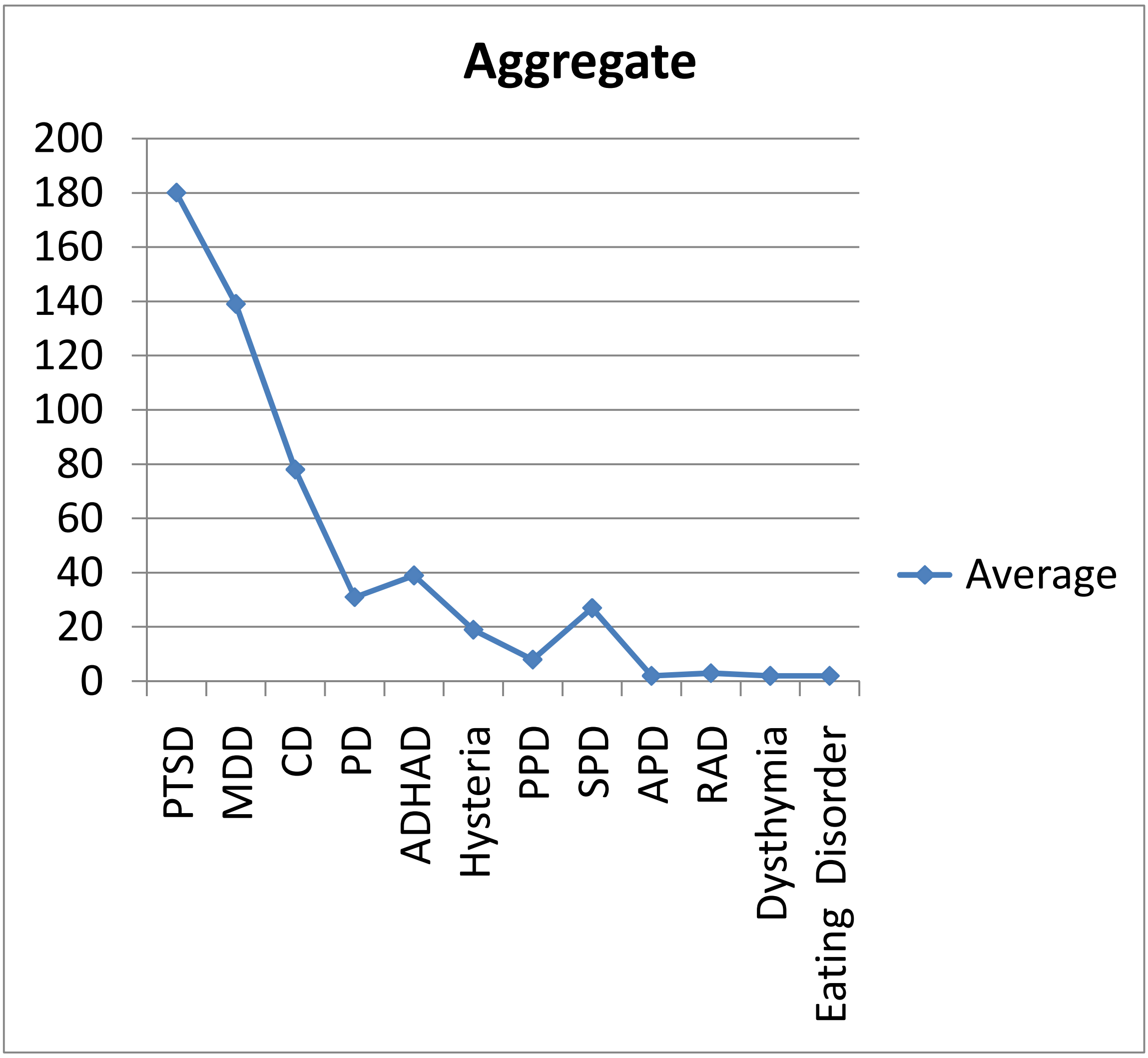
Gutka : 1male uses Gutka in this category , n=13 (7.69%), total in the range 1 , n=28 (4.00%) .

Figure 11



(**Aggregate) Observations in 720 Natural Orphans (See Figure 12)**
Stress Disorders :PTSD 180/720 (25%),MDD 139/720 (19.31%), CD 78/720 (10.83%) PD 31/720(4.31%) PD 31/720(4.31%) ADHD 39/720(2.64%) Female Hysteria 19/720(1.11%) PPD 8/720 (1.11%), SPD 27/720(3.75%) APD 2/720(0.42%)RAD3/720(0.42%), Dysthymia 2/720(0.28%), Eating Disorder 2/720(0.28%)

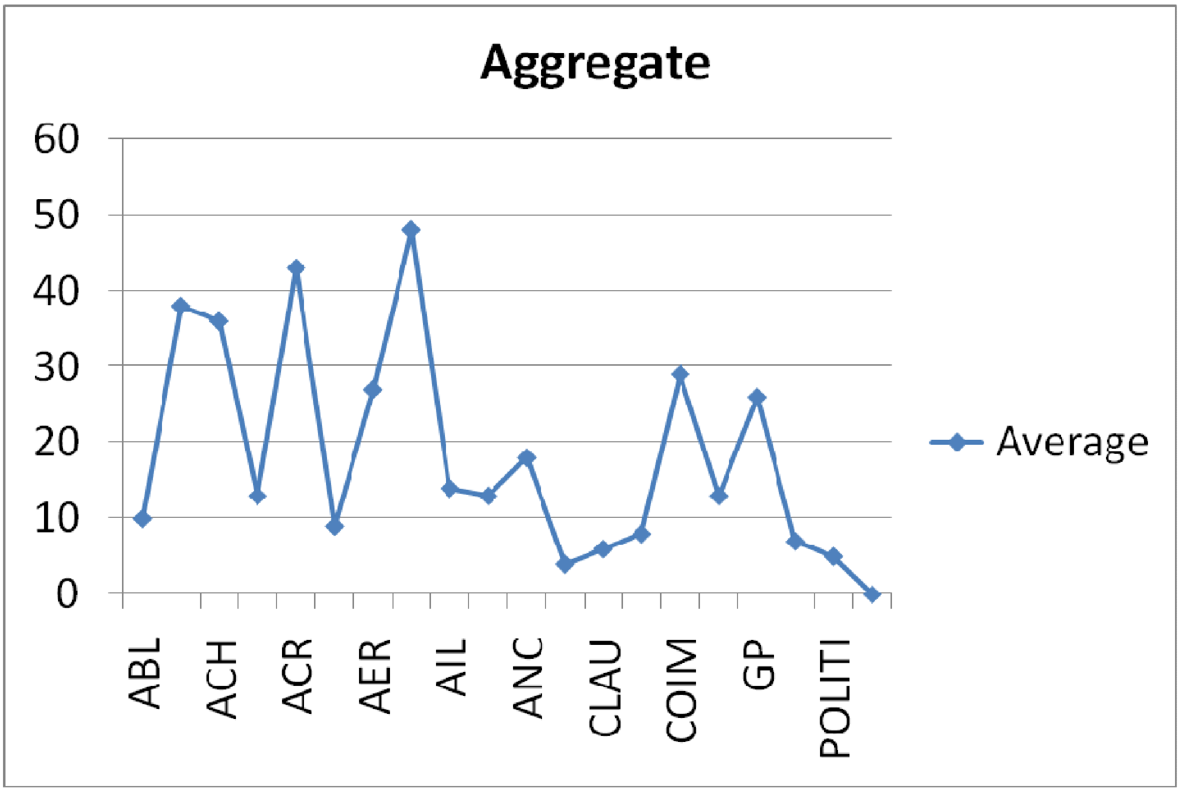
Figure 12



Aggregate observations in 720 Natural Orphans (See Figure 13)

Phobias :ABL 10/720(1.39%), ENT 38/720(5.28%)ACH 36/720(5.0%), ACU13/720(1.81%), ACR 43/720(5.97%) ARP 9/720 (1.25%)AER 27/720(3.75%) AGO 8/720(6.67%)AIL14/720(1.94%) ALT 13/720(1.81%) ANC 18/720(2.50%) ATE 4/720(0.56%), CLAU6/720(0.83%) CLITH 8/720(1.11%) COIM 29/720(4.03%) ENOCH 13/720(1.81%) GP 26/720(3.61%), LALI 7/720 (0.69%) SCIOP 11/720(1.53%).

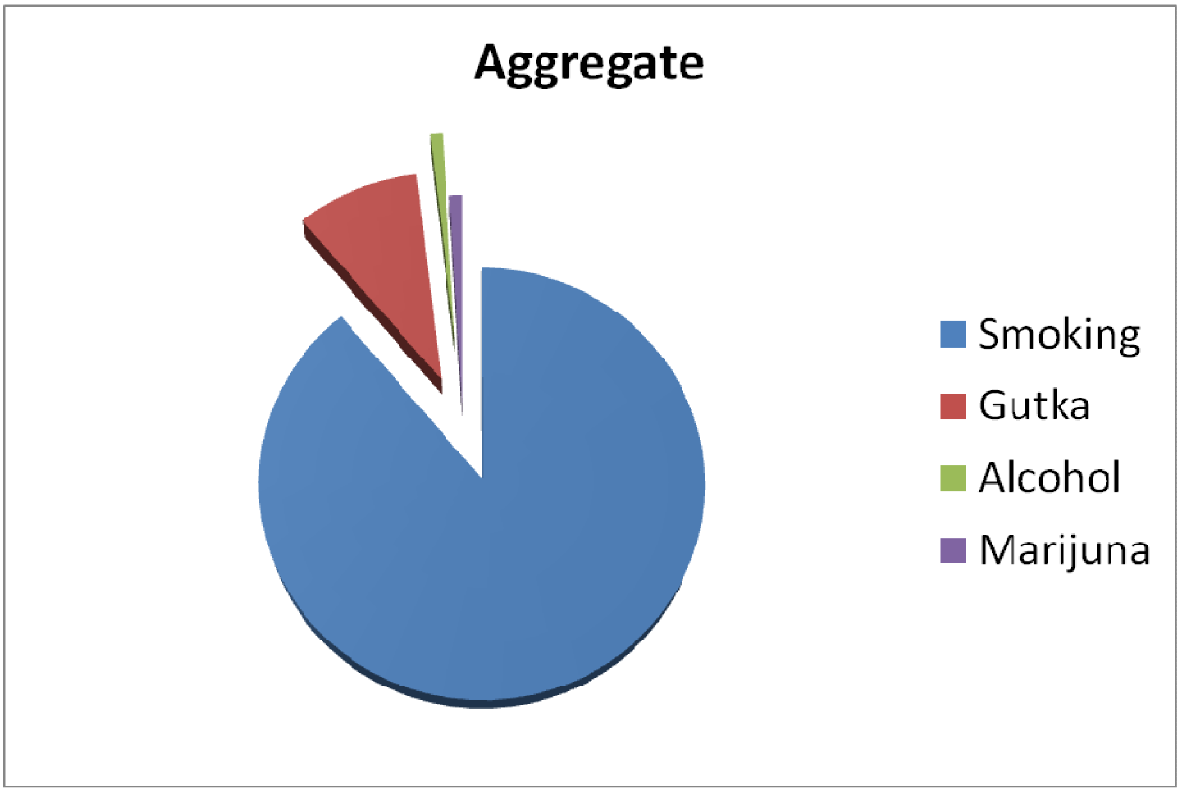
Figure 13



Aggregate observations in 720 natural orphans (See Figure 14)

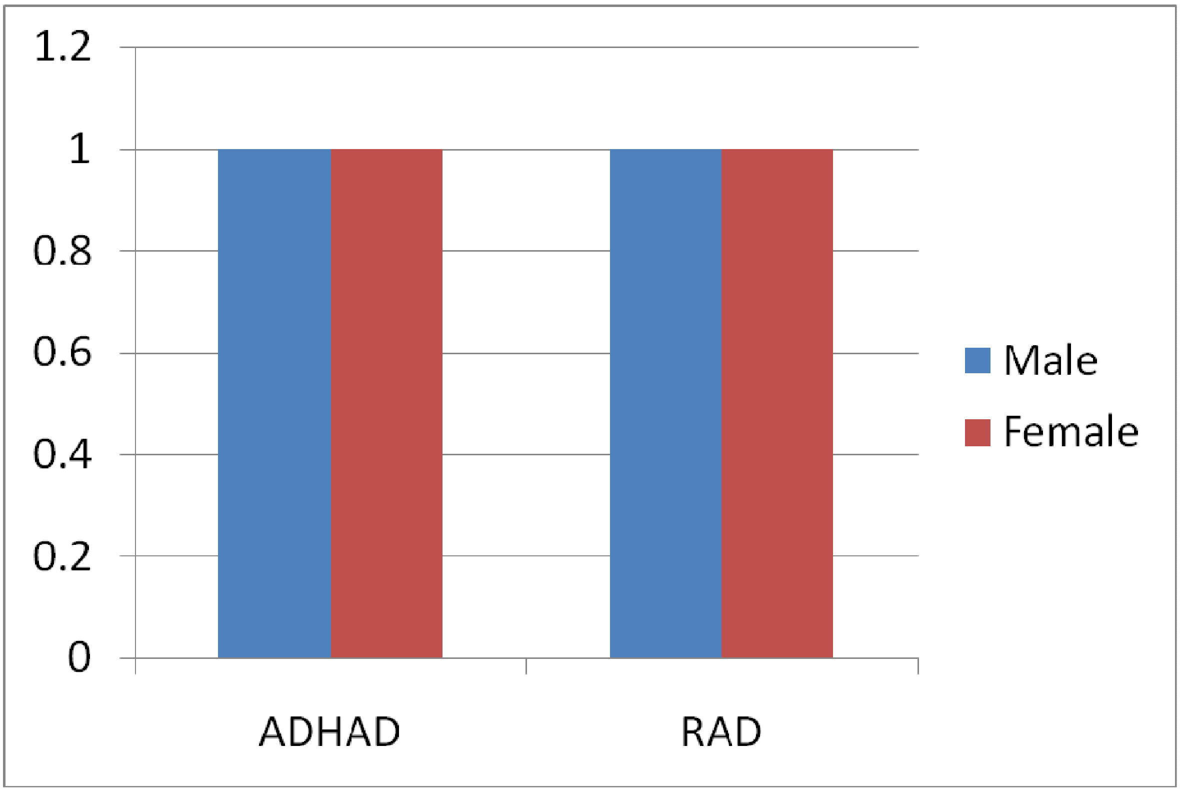
Smoking :96/720(13.33%), **Gutka:** 10/720(1.39%), **Alcohol:** 1/720(0.14%), **Marijuna** :1/720(0.14%)

Figure 14



Orphans of Armed conflict total 442 , divided in 4 groups , 0-5 , 6-14, 15-18 and 19-25
[These are those Orphans whose parents mainly fathers have died of armed violence]
0-5 Age Group (See Figure 15)
n = 22 Male n= 12 Female n=10
Stress Disorders : ADHD is found in 1 male , n=12 (8.33%) , in female 1 , n=10 (10%, total in the range 2 n= 22 (9.09%)
RAD is found in 1 male , n=12(8.33%), female 1 , n=10 (10%), total in the range 2, n= 22 (9.09%).

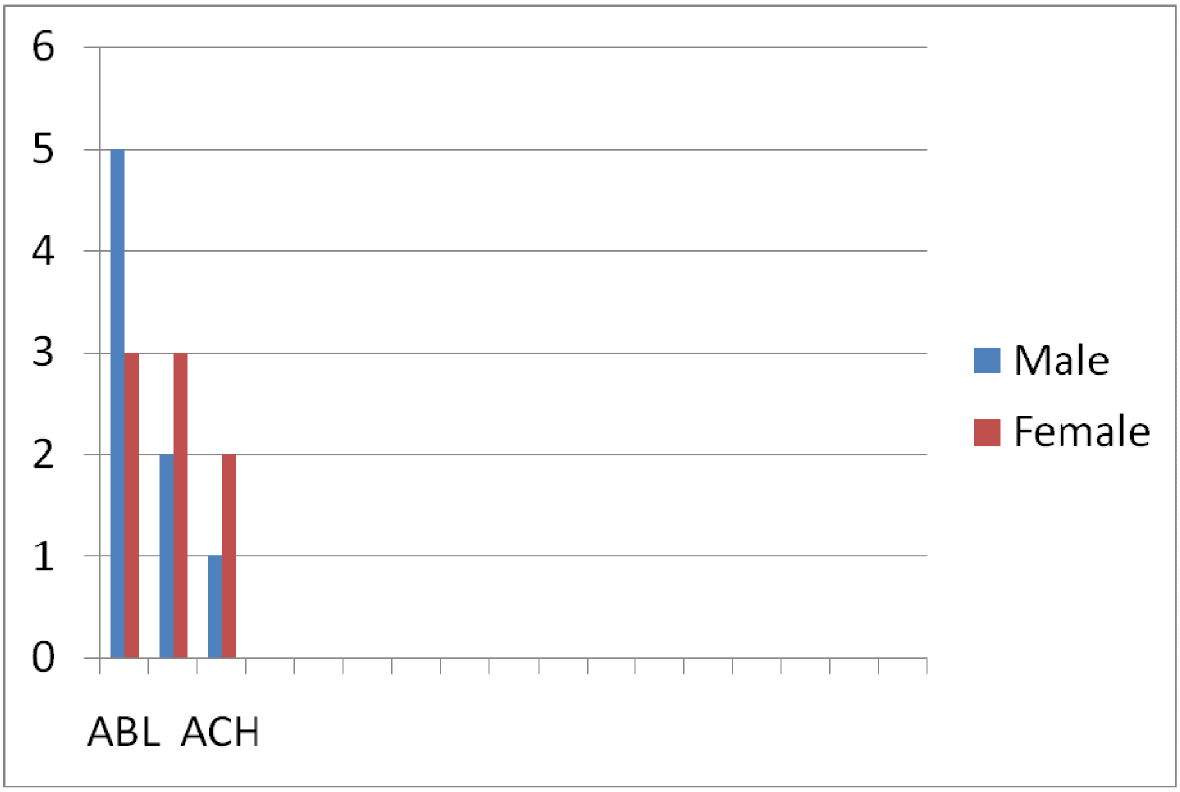
Figure 15



Orphans of Armed Conflict
0-5 Age Group
n = 22 Male n= 12 Female n=10 out of 442 (See Figure 16)

Phobias: ABL is found in 5 males , n=12 (41.67%), females 3 , n= 10 (30.0%), total in the range 8 , n=22 (36.36)
ENT is found in 2 males , n=12 (16.67%) , females 3 , n= 22 (22.73 %)
ACH is found in 1 male n=12 (8.33%), females 2 , n=10 (20.0%), total in the range 3 , n=22 (13.64%)

Figure 16



Orphans of Armed Conflict
6-14 Age Group (See Figure 17)
n=285 Male n= 124 , Female n=161 out of 442

Stress Disorders: PTSD is found in 35 males , n= 124 (28.23 , females 40 , n=161(24.84%), total in the range 75 , n=285 (26.32%)

MDD is found in 26 males , n=124 (20.97%), females 40 , n=161 (24.84%), total in the range 66, n=285 (23.16 %)

CD is found in 11 males , n=124 (8.83%) , females 12 , n= 161 (7.45) total in the range 23 , n=285 (8.07%).

PD is found in 5 males , n=124 (4.03%) , females 7 n=161 (4.35%) , total in the range 12 , n=285 (4.21%).

ADHD is found 3 males , n=124 (2.42%) , females 5 , n= 161 (3.11%) total in the range 8 , n= 285 (2.81%).

Female Hysteria is found in 8 females , n=161 (4.97%) , total in the range 8 , n=285 (2.81%).

PPD is found in 1 male , n= 124 (0.81%) , females 3 , n= 1616 (1.86%), total in the range, 4 , n= 285 (1.40%)

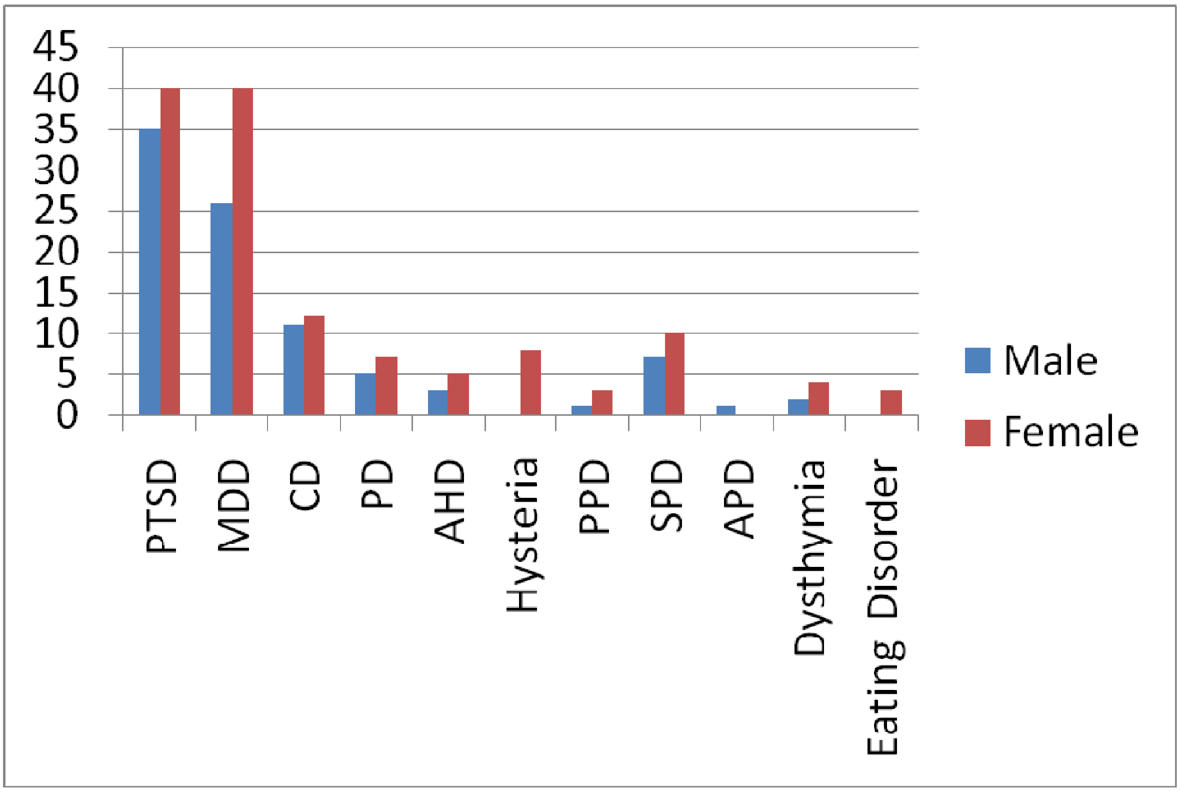
SPD is found in 7 males , n= 124 (5.65) , females 10 , n= 161 (6.21%) total in the range 17 , n=285 (5.56%).

APD is found in 1 male , n=124 (0.81%), total in the range 1 , n= 285 (0.35%)

Dysthymia is found in 2 males , n= 124 (1.61%), females 4 , n= 161 (2.48%) total in the range 6 , n=285 (2.11%).

Eating Disorder are found in 3 females , n= 161 (1.86%), total in the range 3 , n=285 (1.05%).

Figure 17



Orphans of Armed Conflict
6-14 Age Group (See Figure 18)
n=285 Male n= 124 , Female n=161 out of 442

Phobias :ABL is found in 2 males , n=124 (1.61%) , female 1 , n=161 (0.62%) , total in the range 3 , n= 285 (1.05%)

ENT is found in 1 male , n= 124 (0.81%) , females 3 , n=161 (1.86%) , total in the range 4 , n= 285 (1.40%)

ACH is found in 2 females , n= 161 (1.24%) , male 1 n= 124 (0.81 %), total in the range 3 , n= 285 (1.05%)

ACU is found in 3 females , = 161 (1.86 %) , total in the range 3 , n= 285 (1.05%)

ACR is found in 9 males , n=124 (7.26%) , females 12 , n= 161 (9.37%) , total in the range 21 , n= 285 , (7.37%)

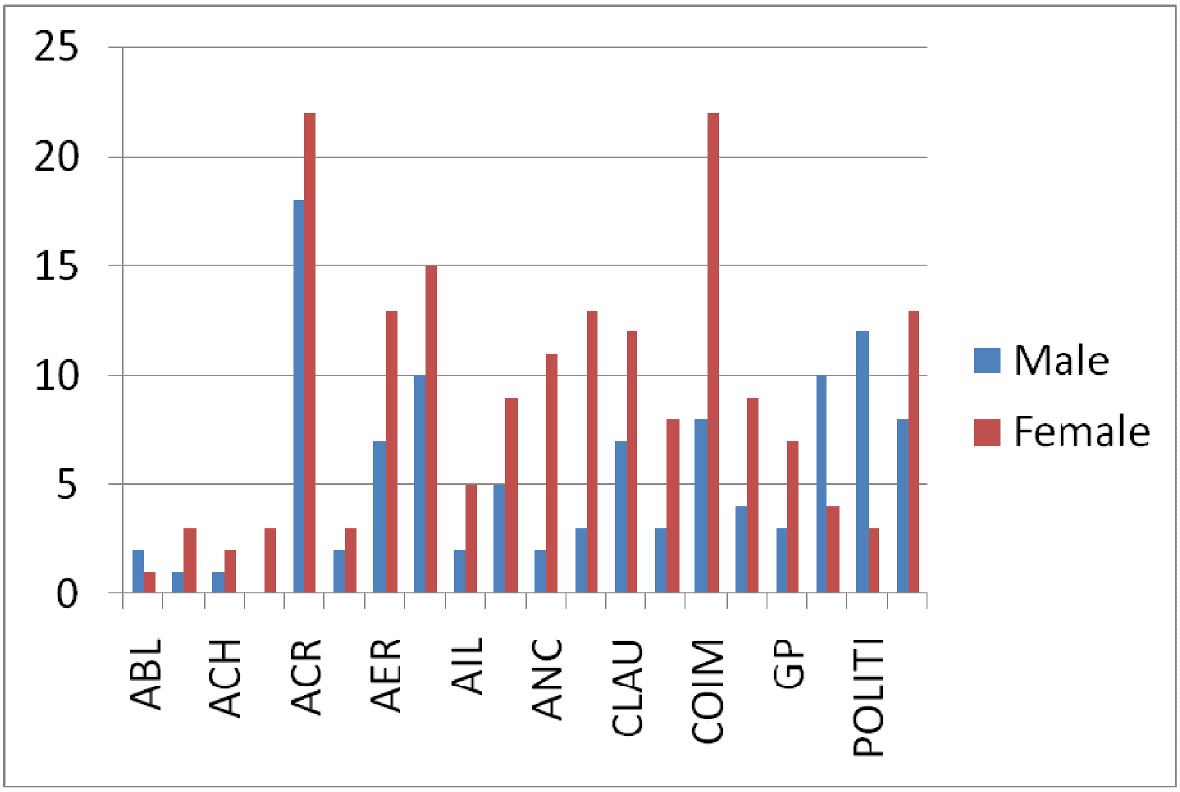
ARP is found in 2 males , n=124 (1.61%), females 3 , n= 161 (1.86%), total in the range 5 , n=285 (1.75%)

AER is found in 7 males , n=124 (5.65%) , females 13 , n=161 (8.07%), total in the range 20 , n=285 (7.02%)

AGO is found in 7 males , n=124 (5.65%), females 10 n= 161 (6.21%) , total in the range 17 , n= 285 (5.96) .

AIL is found in 2 males , n= 124 (1.61%), females 5 n=161 (3.11%) total in the range 7 , n= 285 (2.46%)
ALT is found in 5 males , n= 124 (4.03%) , females 9 , n=161 (5.59%) , total in the range 14 , n= 285 (4.00%)
ANC is found in 2 males , n=124 (1.61%), females 11 , n=161 (6.83%) , total in the range 13 , n=285 (4.85%).
ATE is found in 3 males , n=124 (2.42%), females 13 , n- 161 (8.07%), total in the range 16 , n=285 (5.65%)
CLAU is found in 7 males , n= 124 (5.65%), females 12 , n= 161 (7.45%), total in the range 19 , n= 285 (6.67%).
CLITH is found in 3 males , n=124 (2.42%) , females 8 , n= 161 (4.97%) , total in the range 11 , n= 285 (3.86%)
COIM is found in 8 males , n=124 (6.45%), females 22, n= 161 (13.66%), total in the range 30 , n= 285 (10.53%)
ENOCH is found in 4 males , n= 124 (3.23%), females 9, n= 161 (5.59%) , total in the range 13 , n= 285 (4.56%)
GP is found in 3 males , n=124 (2.42%) , females 7 , n= 161 (4.35%) , total in the range 10 , n=285 (3.51%)
LALI is found in 10 males , n=124 (8.06%) , females 4 , n=161 (2.48%), total in the rnage 14 , n=285(4.91%).
POLITI is found in 12 males , n=124 (9.68%), total in the range 15 , n=285 (5.26%)
SCIOP is found in 8 males , n=124 (6.45%), females 13 , n= 161 (8.07%) total in the range 21 , n= 285 (7.37%)

Figure 18

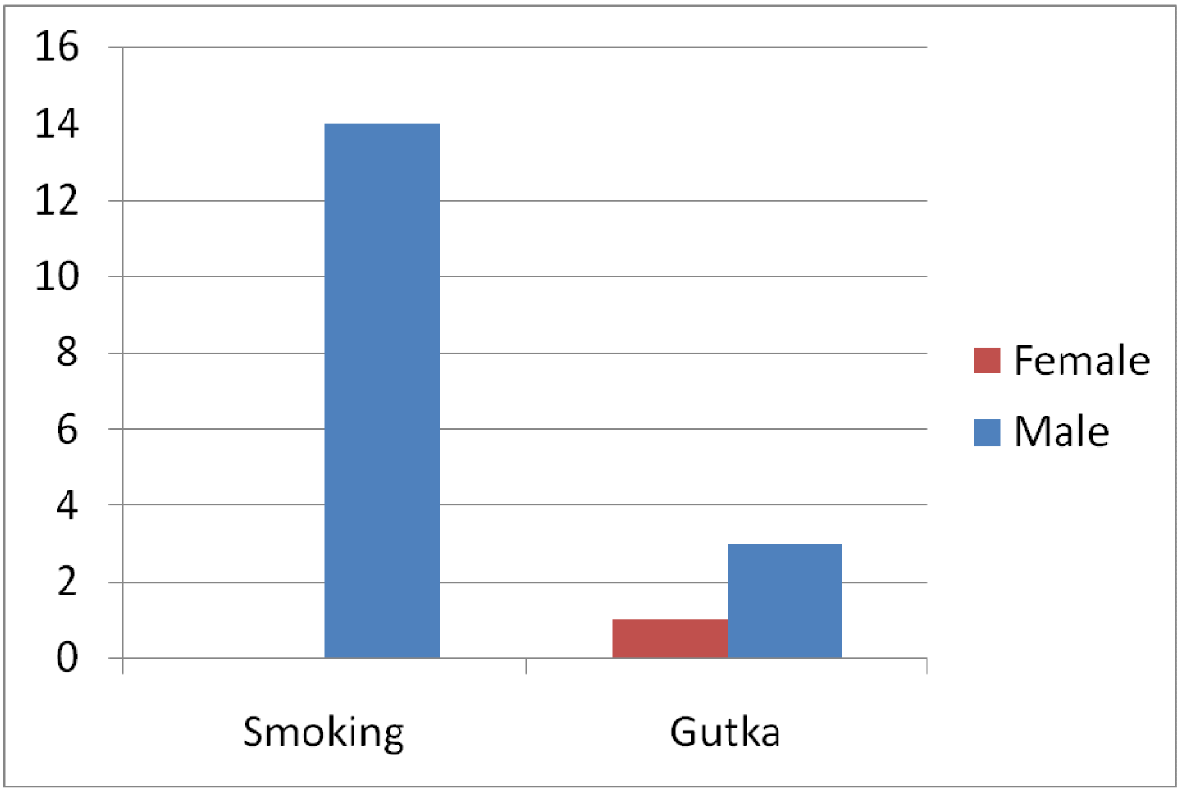


Orphans of Armed Conflict
6-14 Age Group (see Figure 19)
n=285 Male n= 124 , Female n=161 out of 442

Smoking : Smoking habit is found in 14 males , n=124 (11.29%), total in the range 14 , n=285 (4.91%).

Gutka habit in 3 males , n=124(2.41%) , female 1 , n= 161 (0.62%) , total in the range 4 , n=285 (1.40%).

Figure 19



Orphans of Armed Conflict
15-18 Age Group (See Figure 20)
n=97 Male n= 50 , Female n=47 out of 442

Stress Disorders :PTSD is found in 14 males , n=50 (28%) , females 15 , n=47 (31.91%) , total in the range 29 , n= 97 (29.90%)

MDD is found in 5 males , n= 50 (10%) , female 7 , n= 47 (14.89%) , total in the range 12 , n= 97 (12.37%) .

CD is found in 3 males , n= 50 (6.0%) , females 3 , n= 47 (6.38%) total in the range 6 , n= 97 (6.19%).

PD is found in 2 males , n= 50 (4.0 %) , females 2 n= 47 (4.26%) , total in the range 4 , n= 97 (4.12%).

Female Hysteria is found in 2 females , n= 47 (4.26%) , total in the range 2 , n= 97 (2.06%) .

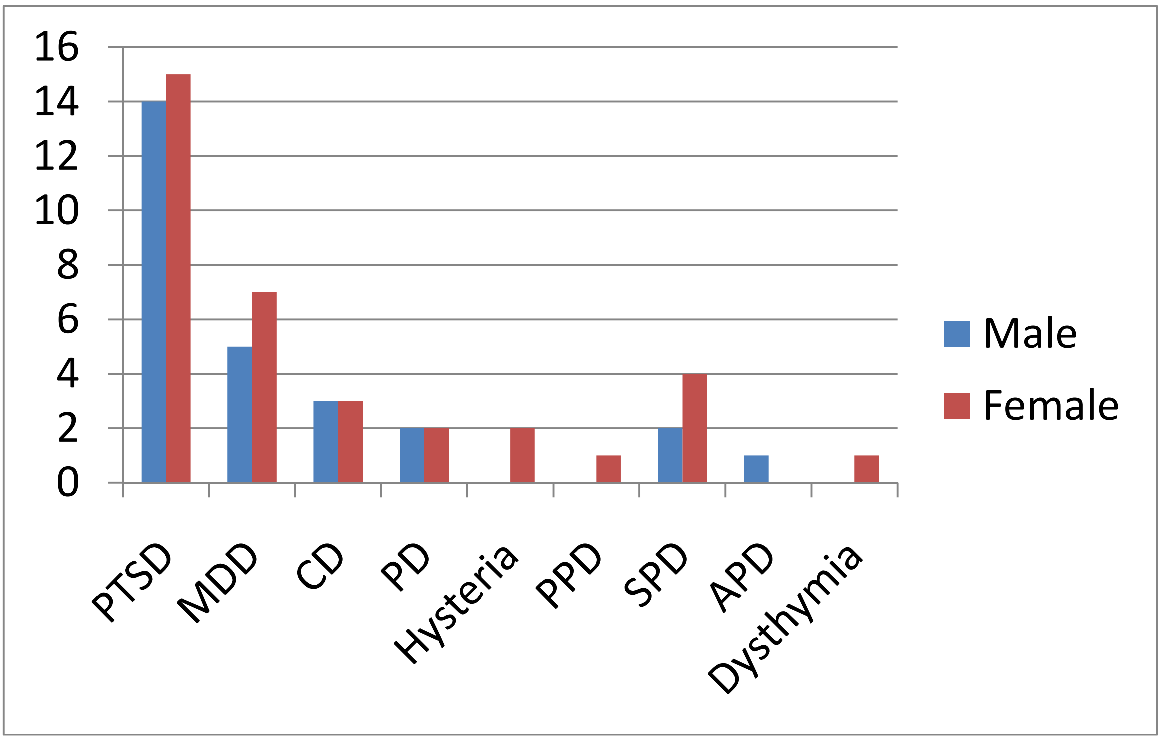
PPD is found in 1 female , n= 47 (2.13%) , total in the range 1 , n= 50 (1.03%)

SPD is found in 2 males , n= 50 (4%) , females 4 , n= 47 (8.51%) , total in the range 6 , n= 97 (6.19%).

APD is found in 1 male , n= 50 (2.0%) , total in range 1 , n= 97 (1.03%)

Dysthymia is found in 1 female , n= 47 (2.13%) , total in the range 1 , n=97 , (1.03%)

Figure 20



Orphans of Armed Conflict

15-18 Age Group (See Figure 21)

n=97 Male n= 50 , Female n=47 out of 442

Phobias: ACH is found in 1 female , n=47 (2.13%) , total in the range 1 , n=97(1.03%)

ACU is found in 2 females , n= 47 (4.26%) , total in the range 2 , n= 97 (2.06%)

ACR is found in 1 male , n= 50 (2.00%) , females 2 , n=47 (4.26%), total in the range 3 , n= 97 (3.09)

AER is found in 2 males , n= 50 (4.0%) , females 7 , n= 47(14.89%) , total in the range 9 , n=97 (9.28%).

AGO is found in 3 males , n= 50 (6.0%) , females 6 ,n= 47 (12.77%), total in the range 9,n=97(9.2 %)

ANC is found in 1 male , n=50 (2.0%), females 3 , n=47 (6.38%) , total in the range 4 , n=97 (2.06%)

ATE is found in 2 females , n=47 (4.26%) , total in the range 2 , n=97 (2.06%)

CLAU is found in 1 female , n= 47 (2.13%) , total in the range 1 n=97 (1.03%)

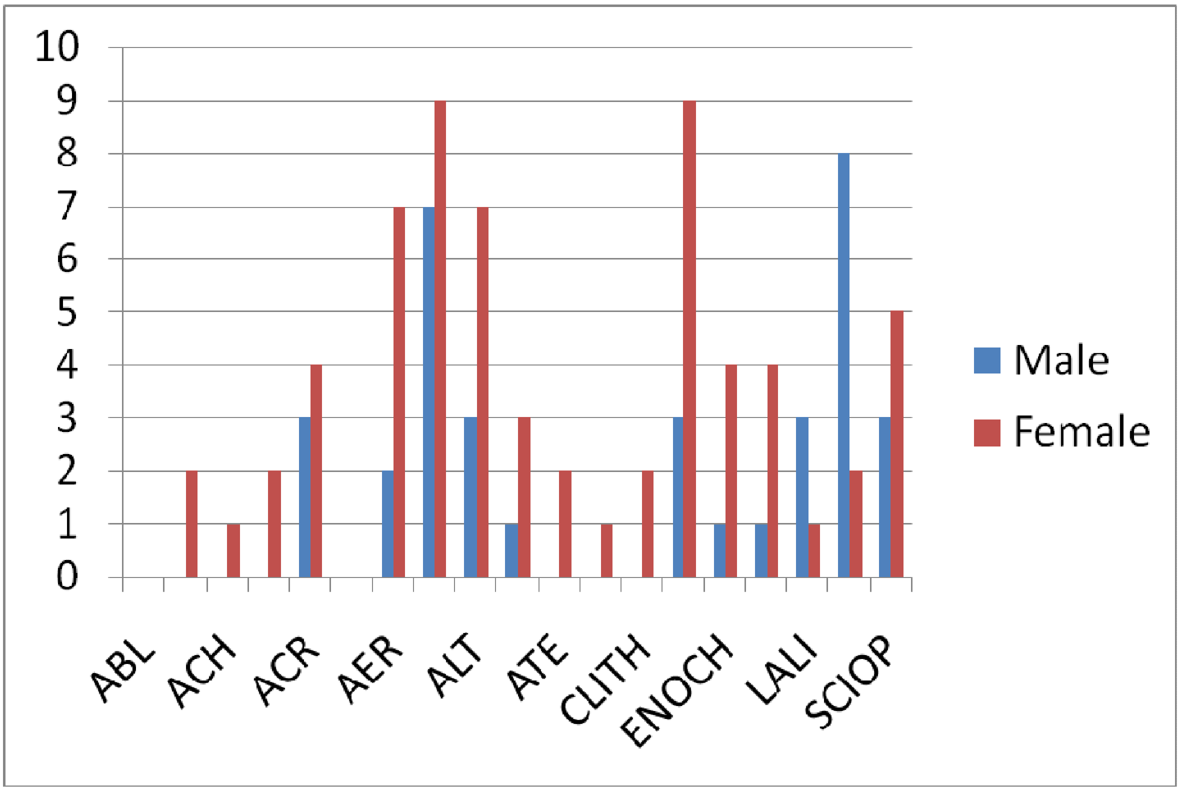
CLITH is found in 2 females n=47 (4.26%) , total in the range 2 , n= 97 (2.06%)

ENOCH is found in 1 male n=50(2.0%), females 4 , n=47 (8.51%) , total in the rnage 5 , n= 97 (5.15%).

GP is found 1 male , n=50 (2.0%) , females 4 , n=47 (8.51%) total in the range 5 , n=95 (5.15%)

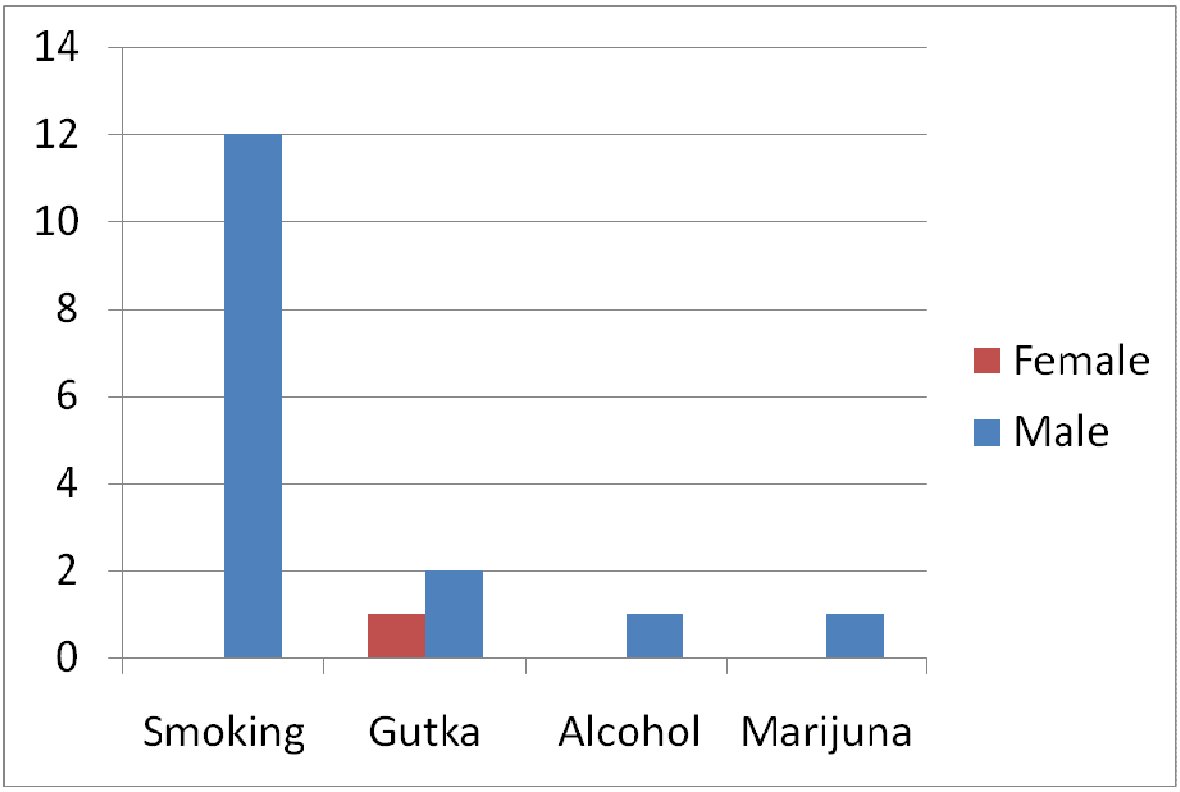
LALI is found in 3 males n=50, (6.0%) , female 1 , n=47 (2.13%) , total in the range 4 , n= 97 (4.12 %)
POLITI is found in 8 males , n= 50 (16.0%) , females 2, n= 47 (4.26 %) , total in the range 10 , n= 97 (10.31%)
SCIOP is found in 3 males , n=50 (6.0%) , females 5 n=47 (10.64%) total in the range 8, n= 97 (8.25%)

Figure 21



Orphans of Armed Conflict
15-18 Age Group
n=97 Male n= 50 , Female n=47 out of 442 (See Figure 22)
Smoking : 12 males use cigarettes , hubble-bubble n=50 (24 %) total in the range 12 , n=97 (12.37%) .
Gutka :2 males take Gutka , n=50 (2%) , 1 female uses Gutka , n= 47 (2.12%) , total in the range 3 , n=97 (3.09%)
Alcohol : 1 male is alcoholic, n=50 (2%) , total in the range 1 , n=97 (1.03%)
Marijuna: 1 male consumes cannabis , n=50 (2%) , total in the range 1 , n=97 (1.03%)

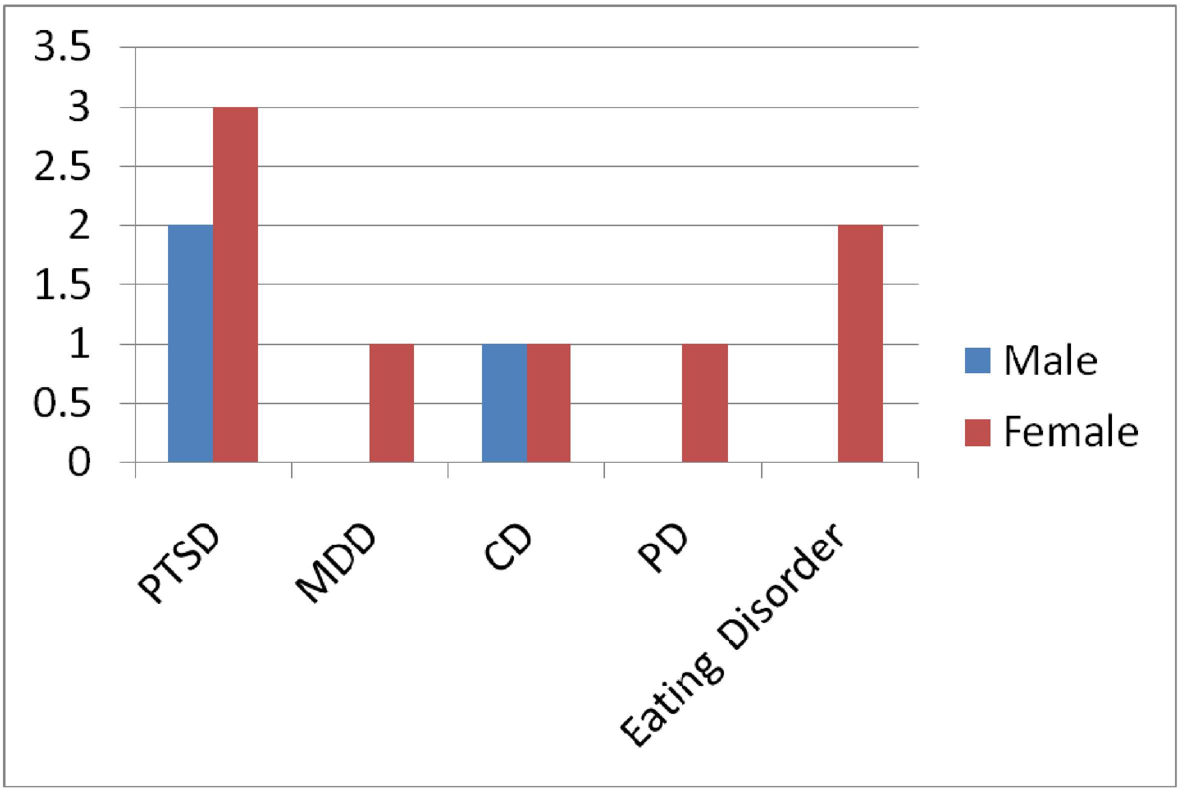
Figure 22



Orphans of Armed Conflict
19-25 Age Group (See Figure 23)
n=38 Male n=21 Female n=17 out of 442

Stress Disorders: PTSD is found in 2 males , n=21 (9.52%) , females 3 , n=17 (17.65%), total in the range 5 , n= 38 (13.16%)
MDD is found in 1 female , n= 17 (5.88%) , total in the range 1 , n= 38 (2.63%)
CD is found in 1 male , n=21 (4.76%), female 1 , n=17 (5.88%) , total in the range 2 , n=38 (5.26%).
PD is found in 1 female n= 17(%.88%), total in the range 1 , n= 38 (2.63%)
Eating Disorders are found in 2 females , n=17 (11.76%) , total in the range 2 , n= 38 (5.26%)

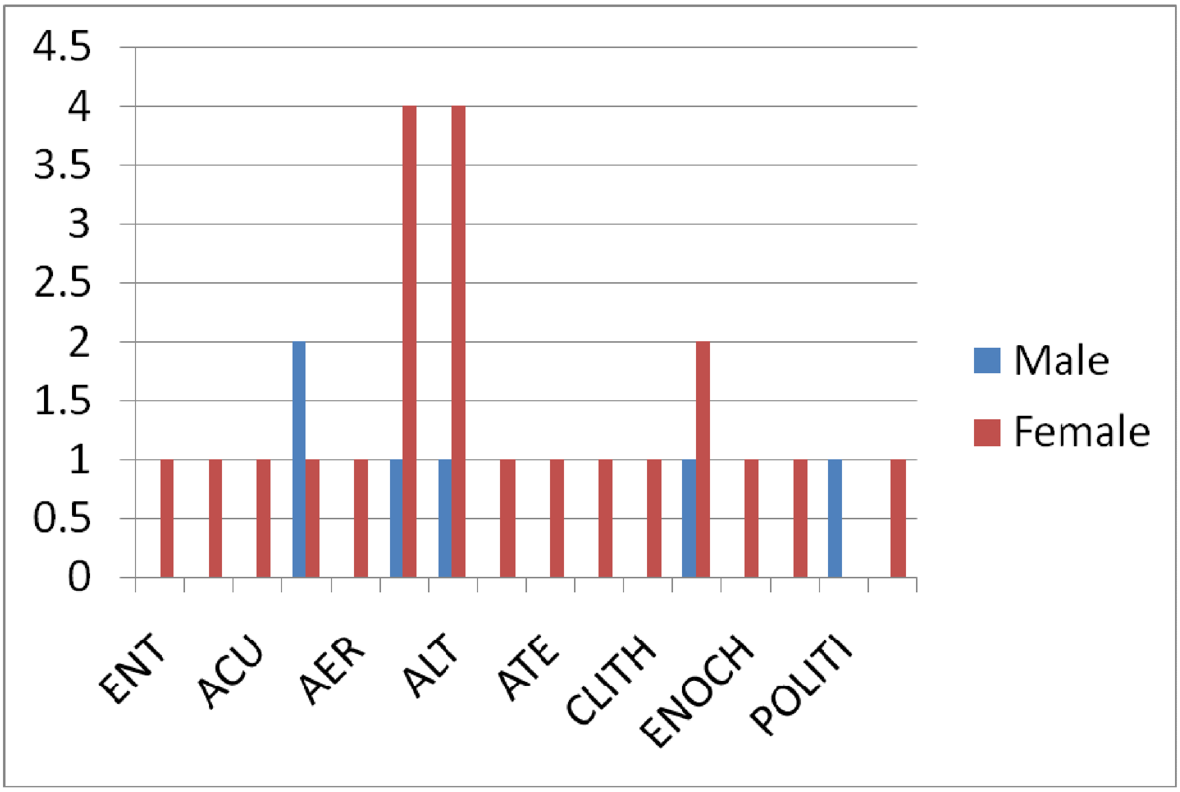
Figure 23



Orphans of Armed Conflict
19-25 Age Group (See Figure 24)
n=38 Male n=21 Female n=17 out of 442

Phobias: ENT is found in 1 female , n=17 (5.88%) , total in the range 1 , n=38(2.63%)
ACH is found in 1 female , n=17(5.88%), total in the range 1 , n=38 (2.63%)
ACU is found in 1 female , n=17 (5.88%) total in the range 1 , n= 38(2.63%)
ACR is found in 1 female , n=17(5.88%) , total in the range 1 , n=38 (2.63%)
AGO is found in 1 male , n=21 (4.7%), females 2 , n=17 (11.76%), total in the range 3 , n= 38 (7.89%)
ALT is found in 1 male , n=21 (4.76%), females 4 , n= 17 (23.53%) , total in the range 5 , n= 38 (13.16%)
ANC is found in 1 female , n= 17 (5.88%) , total in the range 1, n= 38(2.63%)
ATE is found in 1 female n=17 (5.88%)total in the range 1 , n= 38 (2.63%)
CLAU is found in 1 female n=17 (5.88%)total in the range 1 , n= 38 (2.63%)
CLITH is found in 1 female n=17 (5.88%)total in the range 1 , n= 38 (2.63%)
COIM is found in male , n= 21 (4.76%) , females 2 , n=17(7.89%) , total in the range 3 , n= 38 (7.89%)
ENOCH is found in 1 female , n=17 (5.88%) , total in the range 1 , n= 38 (2.63%)
GP is found 1 female , n= 17 (5.88%) , total in the range 1 , n= 38 (2.63%)
POLITI is found in 1 male , n= 21(4.76%) total in the range 1 , n= 38 (2.63%)
SCIOP is found in 1 female , n= 17 (5.88%) , total in the range 1 , n=38 (2.63%)

Figure 24



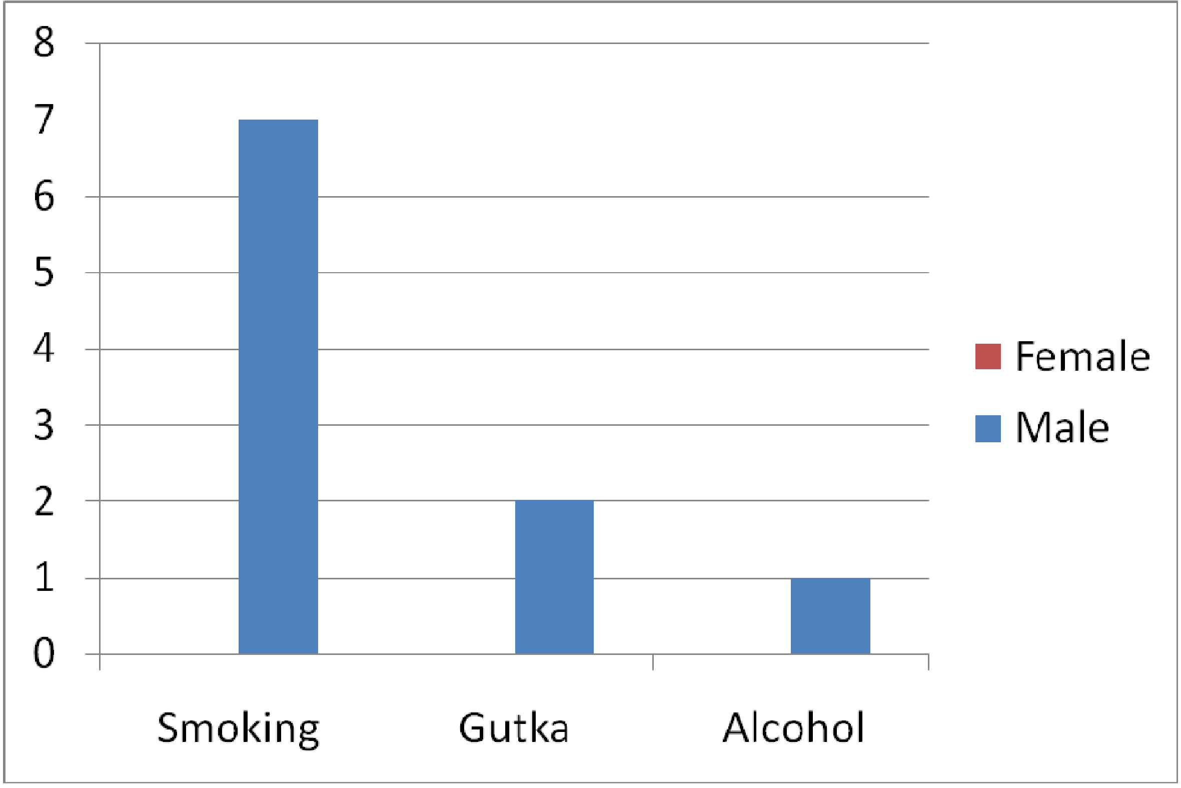
Orphans of Armed Conflict
19-25 Age Group (See Figure 25)
n=38 Male n=21 Female n=17 out of 442

Smoking : 7 males use cigarettes / tobacco products , n=21 (33.33%) total in the range 7, n=38 18.42%

Gutka :2 males take Gutka , n=21 (9.52%) total in the range 2, n= 38 (5.25)

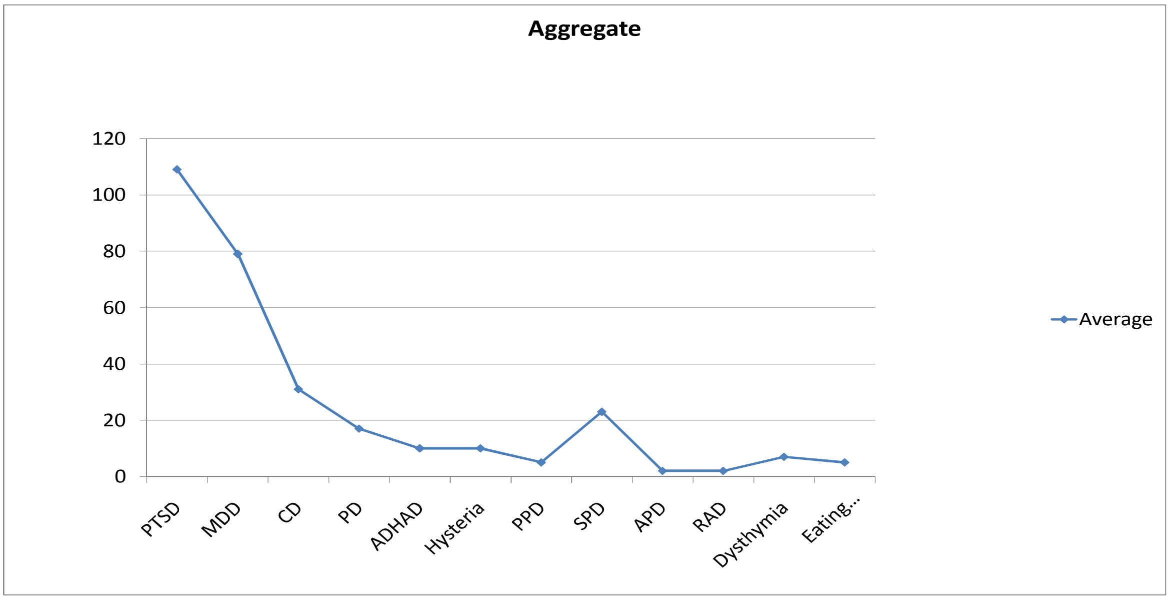
Alcohol is taken by 1 male , n=21 (4.76%) total in the range 1 , n=38 (2.63%)

Figure 25



Orphans of armed Conflict 442 (Aggregate)
Stress Disorder: PTSD 109/442(24.66%), MDD 79/442(17.87%)CD 31/442(7.01%), PD 17/442(3.85%)ADHD 10/442 (2.26%), Female Hysteria 10/442 (2.26%), PPD 5/442(1.13%), SPD 23/442(0.45%) APD2/442(0.45%) RAD 2/442(0.45%) Dysthymia 7/442(1.58%) Eating Disorder 5/442(1.13%) **(See Figure 26)**

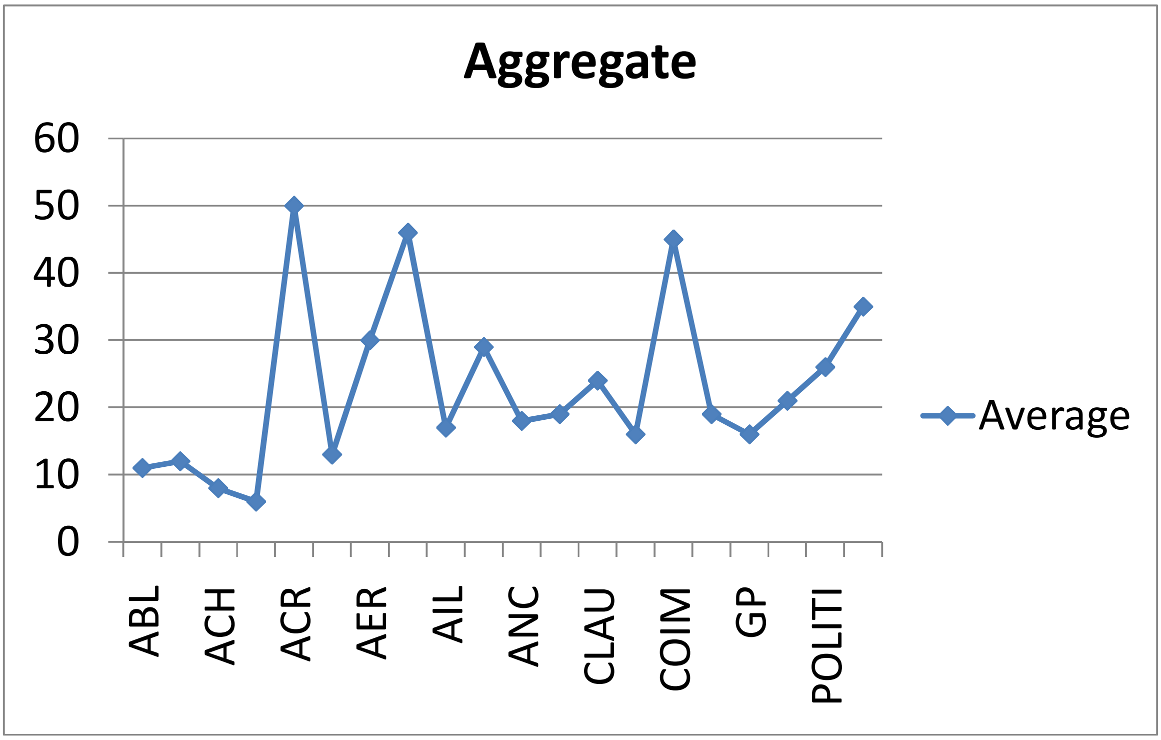
Figure 26



Orphans of Armed Conflict total 442

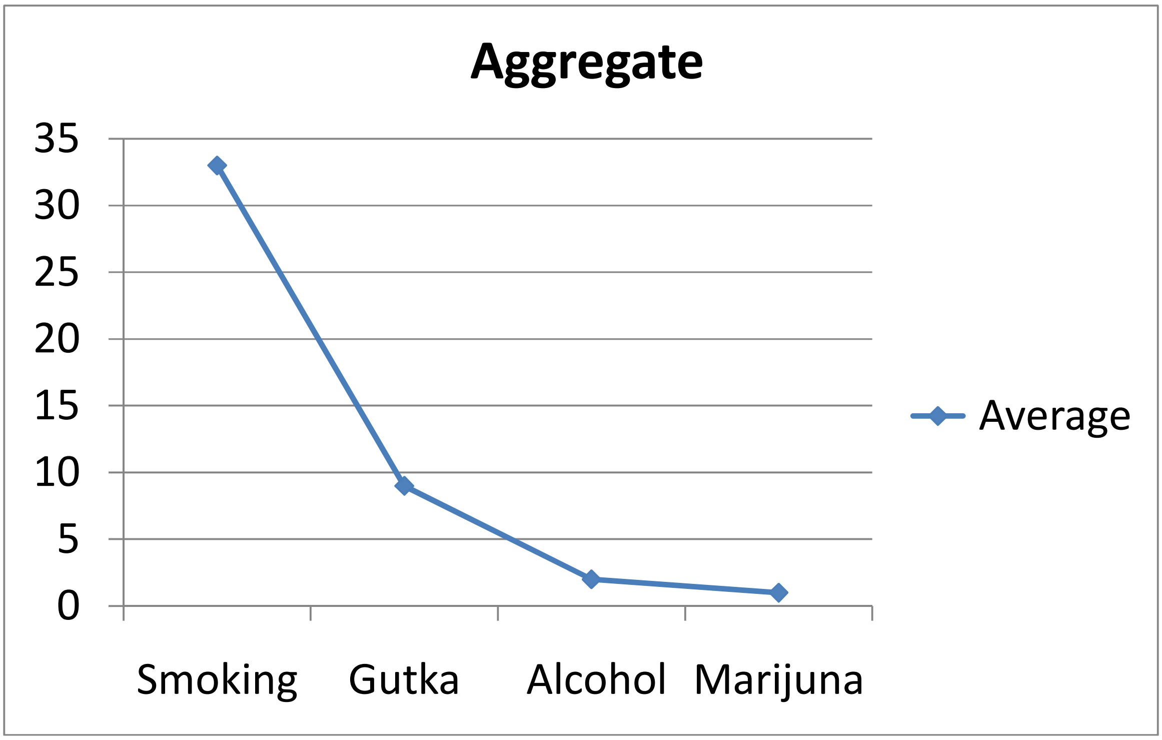
Phobias: ABL 11/442(2.49%) ENT 12/442(2.71%), ACH 8/442(1.81%)ACU 6/442 (1.36%)ACR 25/442(5.66%), ARP 13/442(2.94%)AER 30/442(6.79%)AGO 29/442 (6.56%)AIL 17/442(3.85%) ALT 29/442 (6.56%) ANC 18/442(4.30%), CLAU24/442(5.43%), CLITH 16/442(3.62%) COIM 45/442(10.18%), ENOCH 19/442(4.30%) GP16/442(3.62%) LALI 21/442(5.88%), POLITI 26/442(5.88%), SCIOP 35/442(7.92%). **(See Figure 27)**

Figure 27



Orphans of Armed Conflict Total 442
Smoking : Smoking 33/442(7.47%) , Gutka 9/442(2.04%) **Alcohol** 2/442(0.45%), **Marijuana** 1/442(0.23%) **(See Figure 28)**

Figure 28



IQ Study

Note: Age Group of 19-25 has not been taken up for the study , because the technique used in the study meant to determine IQ gives conflicting results)

Natural Orphans Total 720

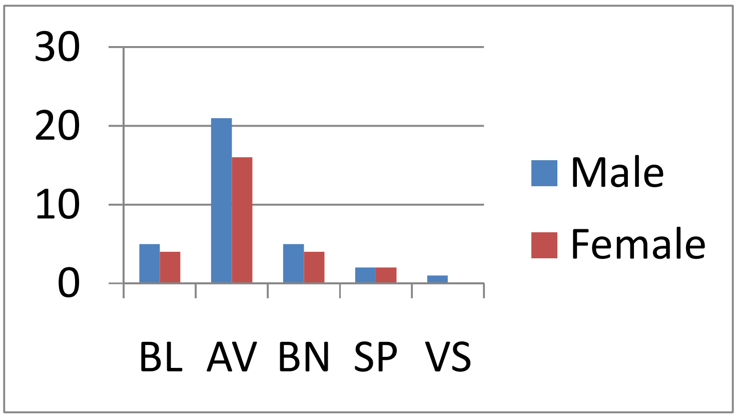
0-5 years Age Group (See Figure 29)

n=60 Male n=34 Female n=26

IQ

Males : BL=05 AV=21 BN=05 SP=02 VS=01
Female : BL= 04 AV = 16BN = 04 SP = 02 VS= 0

Figure 29



Natural Orphans Total 720

6-14 Age Group (See Figure 30)

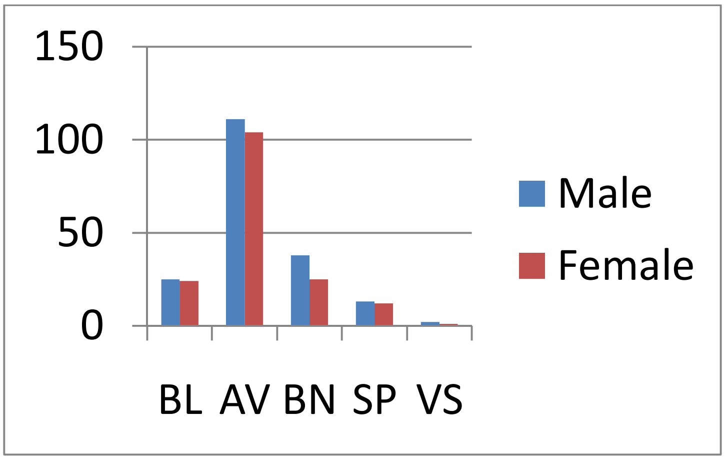
n=355 Male n=189 Female n=166

IQ

Male: BL= 25 AV= 111 BN= 38 SP=13VS=2

Female: BL=24 AV= 104 BN=25 SP=12 VS=1

Figure 30



Natural Orphans Total 720

15-18 Age Group (See Figure 31)

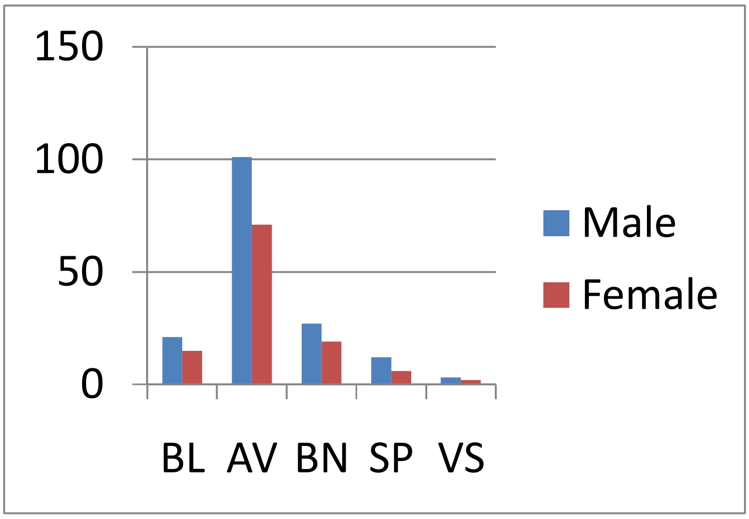
n=277 Male n=164 Female n=113

IQ

Male: BL=21 AV=101 BN= 27 SP=12 VS=3

Female: BL= 15 AV=71 BN=19 SP=6 VS=2

Figure 31



Orphans of Armed Conflict Total 442

0-5 Age Group (See Figure 32)

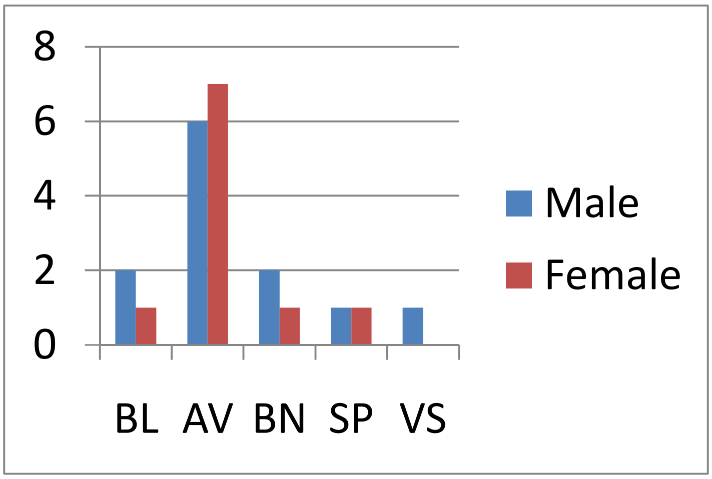
n=22 Male n=12 Female n=10

IQ

Male: BL= 2 AV=6 BN=2 SP=1 VS=1

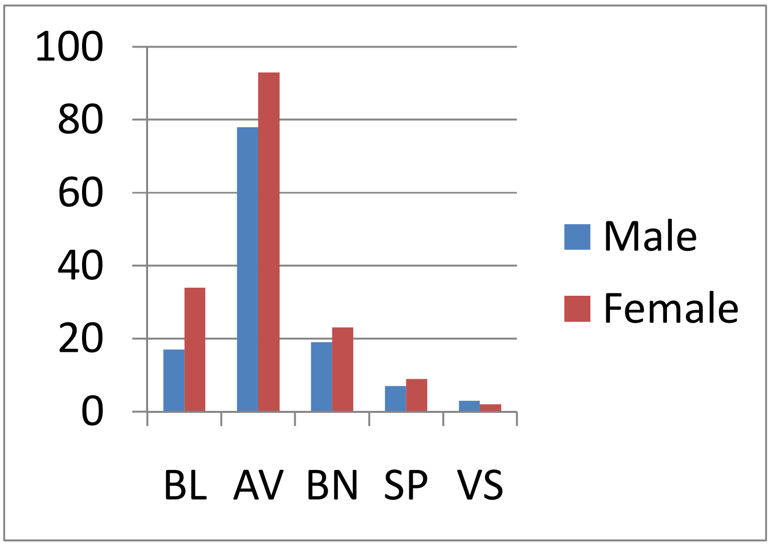
Female: BL=1 AV=7 BN=1 SP=1 VS=0

Figure 32



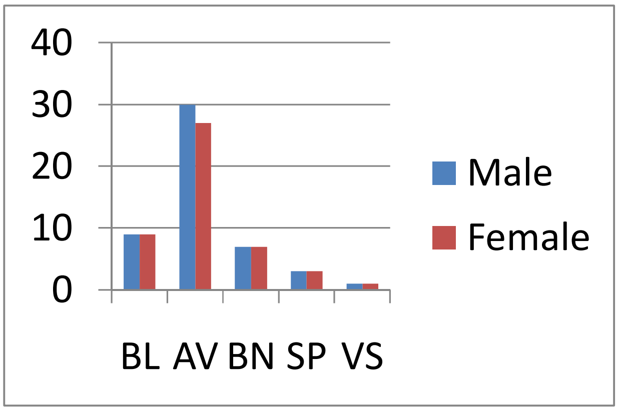
Orphans of Armed Conflict Total 442
6-14 Age Group (Figure 33)
n=285 Male n=124 Female n=161
IQ
Male: BL= 17 AV=78 BN=19 SP=7 VS=3
Female: BL=34 AV=93 BN=23 SP=9 VS=2

Figure 33



Orphans of Armed Conflict Total 442
15-18 Age Group
n=97 Male n=50 Female n=47 (Figure 34)
IQ
Male: BL=9 AV=30 BN=7 SP=3 VS=1
Female: BL=9 AV=27 BN=7 SP=3 VS=1

Figure 34



Observation: It was seen in the study that among Natural Orphans and Orphans of Armed Conflict, the **IQ** of Orphans living in their own families, whether Paternal or Maternal with the active support of community was a bit higher than those staying in Orphanages or hostels .

Randomization

The team took samples from other parts of Kashmir like Srinagar, Budgam ,Pulwama, Tral, Banihal , Pattan , Baramullah , Ganderbal and Shopian , first by identifying orphans which include 987 Males 311 Females in a total of 1298. Only 5% of the orphans in both the categories were selected and responses received by means of questionnaire, even some interviewed for various kind of problems especially in psychological dimension, either in orphanages or community . Orphans, Orphanages, nurture of orphans and challenges were broadly taken up in the study .

The outcomes are very much similar to the results which got reflected in the study of 720 Natural Orphans and 442 Orphans of Armed Conflict from Anantnag .

Randomization was not stratified and each randomisation block consisted of 6-12 orphans and utmost tried to ensure blinding by using basic techniques of child psychology , most importantly which were identical.

Increased susceptibility to depression and anxiety is a major result of the heightened stress levels associated with being an orphan.

The raw and theoretical psycho-therapy code was unblinded only in emergencies. Any such unblinding was critically documented and study monitors checked regularly that code envelopes were not otherwise broken .

Young Orphans may not yet understand the finality of death, they are unable to fully experience the mourning process which helps to cope them and as a result may grow up with unresolved anger, depression and anxiety.

Discussion:

Cortisol is one stress hormone whose levels increase due to touch deprivation. At consistently high levels, it inhibits normal brain tissue development and damages existing brain tissue. Since one of the most impacted regions is the hippocampus, responsible for learning and memory, affection-deprived orphans tend to experience learning difficulties.

Unhealthy social development is another long-term effect; some orphans are typically deprived of consistent and genuine exposure to the love, affection, warmth and care that contributes to healthy social connection. Touch contributes to nervous system development, trust in others, and a sense of self-worth. Touch-deprived children are more susceptible to paranoia, insecurity and distrustfulness.

Description of Anxiety, Depression and Phobia: Anxiety happens as a normal part of life. It can even be useful when it alerts a person to danger. But for some people, anxiety persistently interferes with daily activities such as work, school or sleep. This type of anxiety can disrupt relationships and enjoyment of life, and over time it can lead to health concerns and other problems. In some cases, anxiety is a mental health condition that requires treatment. Generalized anxiety disorder, for example, is characterized by persistent worry about major or minor concerns. Other anxiety disorders — such as panic disorder, obsessive-compulsive disorder (OCD) and post-traumatic stress disorder (PTSD) — have more-specific triggers and symptoms. Sometimes, anxiety results from a medical condition that needs treatment, OCD has been deliberately put absent in the study to avoid confusion.

While as depression is a state of low mood and aversion to activity that can affect a person's thoughts, behavior, feelings and sense of well-being. Depressed people may feel sad, anxious, empty, hopeless, worried, helpless, worthless, guilty, irritable, hurt, or restless. They may lose interest in activities that once were pleasurable, experience loss of appetite or overeating, have problems concentrating, remembering details, or making decisions, and may contemplate or attempt suicide. Insomnia, excessive sleeping, fatigue, loss of energy, or aches, pains, or digestive problems that are resistant to treatment may also be present.

Depressed mood is not necessarily a psychiatric disorder. It may be a normal reaction to certain life events, a symptom of some medical conditions, or a side effect of some drugs or medical treatments. Depressed mood is also a primary or associated feature of certain psychiatric syndromes such as clinical depression.

A phobia is an overwhelming and unreasonable fear of an object or situation that poses little real danger. Unlike the brief anxiety most people feel when they give a speech or take a test, a phobia is long-lasting, causes intense physical and psychological reactions, and can affect one's ability to function normally at work or in social settings.

Several types of phobias exist. Some people fear large, open spaces. Others are unable to tolerate certain social situations. And still others have a specific phobia, such as a fear of snakes, elevators or flying. Not all phobias need treatment, but if a phobia affects one's daily life, professional consultation is needed.

Post-traumatic Stress Disorder (PTSD) : When in danger, it's natural to feel afraid. This fear triggers many split-second changes in the body to prepare to defend against the danger or to avoid it. This “fight-or-flight” response is a healthy reaction meant to protect a person from harm. But in post-traumatic stress disorder (PTSD), this reaction is changed or damaged. People who have PTSD may feel stressed or frightened even when they're no longer in danger.

PTSD develops after a terrifying ordeal that involved physical harm or the threat of physical harm. The person who develops PTSD may have been the one who was harmed, the harm may have happened to a loved one, or the person may have witnessed a harmful event that happened to loved ones or strangers.

PTSD was first brought to public attention in relation to war veterans, but it can result from a variety of traumatic incidents, such as mugging, rape, torture, being kidnapped or held captive, child abuse, car accidents, train wrecks, plane crashes, bombings, or natural disasters such as floods or earthquakes.

Major Depression Disorder or Clinical Depression (MDD): Most people feel sad or low at some point in their lives. But clinical depression is marked by a depressed mood most of the day, particularly in the morning, and a loss of interest in normal activities and relationships -- symptoms that are present every day for at least 2 weeks. In addition, according to the DSM-IV -- a manual used to diagnose mental health conditions – one may have other symptoms with major depression. Those symptoms might include:

- ❖ Fatigue or loss of energy almost every day.
- ❖ Feelings of worthlessness or guilt almost every day.
- ❖ Impaired concentration, indecisiveness.
- ❖ Insomnia or hypersomnia (excessive sleeping) almost every day.

Markedly diminished interest or pleasure in almost all activities nearly every day (called anhedonia, this symptom can be indicated by reports from significant others).Restlessness or feeling slowed down. Recurring thoughts of death or suicide. Significant weight loss or gain (a change of more than 5% of body weight in a month).

Conversion Disorder(CD): Conversion disorder is a mental health condition in which a person has blindness, paralysis, or other nervous system (neurologic) symptoms that cannot be explained by medical evaluation. t is thought that symptoms arise in response to stressful situations affecting a patient's mental health and Conversion disorder is considered a psychiatric disorder in the Diagnostic and Statistical Manual of Mental Disorders fifth edition (DSM-5). Symptoms usually begin suddenly after a stressful experience. People are at risk of conversion disorder if they also have a medical illness, or the other mental health problem of dissociative disorder (escape from reality that is not on purpose) or a personality disorder (inability to manage feelings and behaviours that are expected in certain social situations). Persons who have conversion disorder are not making up their symptoms (malingering). Some doctors falsely believe that this disorder is not a real condition and may tell patients the problem is all in their head. But this condition is real. It causes distress and cannot be turned on and off at will.

The physical symptoms are thought to be an attempt to resolve the conflict the person feels inside. For example, a woman who believes it is not acceptable to have violent feelings may suddenly feel numbness in her arms after becoming so angry that she wanted to hit someone. Instead of allowing herself to have violent thoughts about hitting someone, she experiences the physical symptom of numbness in her arms.

Conversion disorder symptoms may occur because of a psychological conflict.

Symptoms of a conversion disorder include the loss of one or more bodily functions, such as:

- ❖ Blindness
- ❖ Inability to speak
- ❖ Numbness
- ❖ Paralysis

Common signs of conversion disorder include:

- ✓ A debilitating symptom that begins suddenly
- ✓ History of a psychological problem that gets better after the symptom appears
- ✓ Lack of concern that usually occurs with a severe symptom

Panic Disorder (PD) : Panic disorder is a type of anxiety disorder. It causes panic attacks, which are sudden feelings of terror when there is no real danger. One might may feel as if he/she is losing control and may also have physical symptoms, such as:-

- Fast heartbeat
- Chest or stomach pain
- Breathing difficulty
- Weakness or dizziness
- Sweating
- Feeling hot or a cold chill
- Tingly or numb hands

Panic attacks can happen anytime, anywhere, and without warning. One may live in fear of another attack and may avoid places where the person has had an attack. For some people, fear takes over their lives and they cannot leave their homes.

Panic disorder is more common in women than men. It usually starts when people are young adults. Sometimes it starts when a person is under a lot of stress. Most people get better with treatment. Therapy can show the person how to recognize and change one's thinking patterns before they lead to panic. Medicines can also help.

Attention Deficit Hyperactivity Disorder (ADHD): When a child acts without thinking, still sits even after completing the infant period, starts any activity but not finishes , these like features indicate the signs of attention deficit hyperactivity disorder (ADHD). Nearly everyone shows some of these behaviours at times, but ADHD lasts more than 6 months and causes problems in school, at home and in social situations.

The main features of ADHD are:-

- Inattention
- Hyperactivity
- Impulsivity

No one knows exactly what causes ADHD. It sometimes runs in families, so genetics may be a factor. There may also be environmental factors.

A complete evaluation by a trained professional is the only way to know for sure if your child has ADHD. Treatment may include medicine to control symptoms, therapy, or both. Structure at home and at school is important. Parent training may also help.

Female Hysteria: Hysteria was widely discussed in the medical literature of the 19th century. Young girls considered to be suffering from it exhibited a wide array of symptoms including faintness, nervousness, , insomnia, fluid retention, muscle spasm, shortness of breath, irritability, loss of appetite for food and "a tendency to cause trouble".

Paranoid Personality Disorder (PPD): Paranoid personality disorder is a mental health condition in which a person has a long- term pattern of distrust and suspicion of others, but does not have a full-blown psychotic disorder such as schizophrenia.

Schizotypal Personality Disorder (SPD) : Schizotypal personality disorder is a mental health condition in which a person has trouble with relationships and disturbances in thought patterns, appearance, and behaviour.

People with Schizotypal personality disorder may be very disturbed. Their odd behavior may look like that of people with schizophrenia. For example, they may also have unusual preoccupations and fears, such as fears of being monitored by government agencies.

More commonly, however, people with Schizotypal personality disorder behave oddly and have unusual beliefs (such as aliens). They cling to these beliefs so strongly that it prevents them from having relationships.

People with schizotypal personality disorder feel upset by their difficulty in forming and keeping close relationships. This is different from people with schizoid personality disorder, who do not want to form relationships.

Antisocial Personality Disorders(APD): Antisocial personality disorder, also referred to as sociopathy or psychopathy, is characterized by a pervasive pattern of disregard for the rights of others, lying, deception, impulsivity, aggressive behavior, lack of empathy, and lack of remorse.

The early environmental conditions that appear to trigger sociopathy in those with the requisite genetic predispositions include physical or sexual abuse as children and a history of parental separation and loss (Stevens and Price, 1996). Oftentimes, much of their early life was in an orphanage or foster home. Presumably, roughly equal numbers of males and females are subjected to such degraded rearing experiences but males are much more likely to become sociopaths whereas females are much more likely to develop histrionic personality disorders.

Reactive Attachment Disorder (RAD): Reactive attachment disorder is a rare but serious condition in which infants and young children don't establish healthy bonds with parents or caregivers.

A child with reactive attachment disorder is typically neglected, abused or orphaned. Reactive attachment disorder develops because the child's basic needs for comfort, affection and nurturing aren't met and loving, caring attachments with others are never established. This may permanently change the child's growing brain, hurting the ability to establish future relationships. Reactive attachment disorder is a lifelong condition, but with treatment children can develop more stable and healthy relationships with caregivers and others. Safe and proven treatments for reactive attachment disorder include psychological counseling and parent or caregiver education.

Dysthymia : Dysthymia is a mild but long-term (chronic) form of depression. Symptoms usually last for at least two years, and often for much longer than that. Dysthymia interferes with one’s ability to function and enjoy life.

With dysthymia, one may lose interest in normal daily activities, feel hopeless, lack productivity, and have low self-esteem and an overall feeling of inadequacy. People with dysthymia are often thought of as being overly critical, constantly complaining and incapable of having fun.

Eating disorders: Binge-purge is the phrase that describes the eating disorder known as bulimia. One of the most famous bulimics was Princess Diana. Bulimia is often the response to stress and depression. Bulimics derive comfort from food. When such people feel low or angry for some reason, food is their 'pick-me-up.' They gorge themselves, preferably on high-calorie food. This gives them a 'high' helping them to forget their troubles for a little while. Bulimics tend to be closet eaters. They gormandize secretly and then feel ashamed of their gluttony. They then induce themselves to vomit or take laxatives to purge themselves of the feeling of guilt. They have no control over their eating so they treat the effect rather than the cause by vomiting or taking laxatives. After a point bulimics can derive pleasure from the act of vomiting itself.

The pattern of binge and purge can result in ulcers, gastric and dental problems, acute disturbances in the chemical balances of the blood which could lead to heart attacks, sore throats, aching joints, and feelings of weakness, dizziness and apathy.

Intelligence Quotient (IQ):

IQ, is a score derived from one of several standardized tests designed to assess intelligence. The abbreviation "IQ" comes from the German term Intelligenz-Quotient, originally coined by psychologist William Stern.

The first intelligence test was designed by French psychologist Alfred Binet and his colleague Theodore Simon in 1905 as a means of placing schoolchildren in the appropriate grades in public school. Since this first application to educational placement, intelligence testing has developed into a field and industry in its own right. Intelligence tests have varied in terms of their assumptions and applications.

Most intelligence tests were originally developed to be administered to one respondent at a time, or individually.

A. Individual Tests

1. The Binet-Simon Scale

Binet and Simon's original test consisted of 30 subtests involving tasks that children of different ages should be able to perform. If a child could answer the questions that the average nine-year-old could answer, he or she was assigned a Mental Age(MA) of nine.

Each child's MA, as measured by the test, was compared with his or her actual chronological age (CA). When mental age exceeded Chronological Age (eg. a 9year -old with an MA of 9) the child was classified as bright, and assigned to a higher grade level. If CA exceeded MA, the child would be assigned to a lower grade level.

2. The Intelligence Quotient

William Stern argued that a simple comparison between MA and CA - e.g. concluding that "MA > CA" - was insensitive to degrees of comparison.

Instead, Stern advocated using the ratio of MA to CA to measure intelligence. To eliminate decimal points, Stern's formula for this Intelligence Quotient(IQ) (since a quotient is the result of an arithmetic division) was: MA/CA x 100 = IQ. For example, a child with an MA of 9 and a CA of 6 has an IQ of 150, whereas one with an MA of 9 and a CA of 12 has an IQ of 75. When MA = CA, IQ = 100.

3. The Stanford-Binet Intelligence Scale

In 1916 (and several times since), Stanford University psychologist Lewis Terman(1877-1956) revised the original Binet-Simon scale of intelligence. Items that yielded little information were discarded, others were improved, and the resulting test, titled the Stanford-Binet Intelligence Scale, was re-standardized on new populations of children.

The most recent version of the Stanford-Binet includes four designated areas, with its own set of subtests: verbal reasoning; abstract value reasoning; quantitative reasoning; and short-term memory.

4. The Wechsler Tests

The individual intelligence test most often administered today is likely to be one developed by the late American psychologist David Wechsler.

Wechsler's scale consists of two subscales: a verbal scale, and a performance scale. The verbal scale includes questions and tasks involving information, arithmetic, and comprehension. The performance scale includes tests of picture arrangement, puzzle assembly, block design assembly, and identification of elements missing in pictures.

The Wechsler Adult Intelligence Scale-Revised (WAIS-R) is administered to individuals over age 16, while the Wechsler Intelligence Test for Children -Revised (WISC-R) is administered to school-age children.

B. Group Tests

For the sake of expediency and time, many "intelligence" tests -- often tests of achievement or of a particular skill like verbal ability -- are designed to be administered in paper-and pencil form to many individuals simultaneously. Best known among high-school and college students are the Scholastic Aptitude Test (SAT) and the American College Testing (ACT) program. Group tests are convenient and eliminate examiner bias. They are usually limited in the comprehensiveness of their results in comparison with individual tests.

Due to variety of reasons our team applied William Stern technique, because of this Age Group of 19-25 has not been included .

In Anantnag by 2013 there are 720 orphans registered with department of Social Welfare whose fathers died of natural death, out of them 360 orphans have been stopped the grant-in-aid as their mothers or adult[brother or sister]have been appointed under SRO43(Compassionate Appointment) by government[34].

442 Orphans of Armed Conflict identified in Anantnag whose fathers mostly were either militants or counterinsurgents, some of them are getting financial support from the Department of Social Welfare, Government of Jammu and Kashmir under the category ‘Militancy Scholarship Without Discrimination’, most of them are with their paternal or maternal families, some are enrolled in various orphanages of Kashmir but their number is not sizable.

Inferences:-

(**Aggregate) Observations in 720 Natural Orphans**

STRESS DISORDERS :- (See Figure 12)

- POST-TRAUMATIC STRESS DISORDER (PTSD) (25%)
- MAJOR DEPRESSION DISORDER OR CLINICAL DEPRESSION (MDD) (19.31%)
- CONVERSION DISORDER (CD) (10.83%)
- PANIC DISORDER (PD) (4.31%)
- ATTENTION DEFICIT HYPERACTIVITY DISORDER (ADHD OR ADHAD) (2.64%)
- FEMALE HYSTERIA (HYSTERIA) (1.11%)
- PARANOID PERSONALITY DISORDER (PPD) (1.11%)
- SCHIZOTYPAL PERSONALITY DISORDER (SPD) (3.75%)
- ANTISOCIAL PERSONALITY DISORDERS(APD) (0.42%)
- REACTIVE ATTACHMENT DISORDER (RAD) (0.42%)
- DYSTHYMIA (0.28%)
- EATING DISORDER (0.28%)

Phobias :- (See Figure 13)

- ABLUTOPHOBIA- FEAR OF WASHING OR BATHING(ABL) (1.39%)
- ENTOMOPHOBIA- FEAR OF INSECTS(ENT)(5.28%)
- ACHLUOPHOBIA- FEAR OF DARKNESS(ACH)(5.0%)
- ACOUSTICOPHOBIA- FEAR OF NOISE (ACU)(1.81%)

---

[34]) Source: Dr. Zahoor Raina , District Social Welfare Officer ,Anantnag,2013.

- ACROPHOBIA- FEAR OF HEIGHTS (ACR) (5.97%)
- AEROPHOBIA- FEAR OF DRAFTS, AIR SWALLOWING, OR AIRBORNE NOXIOUS SUBSTANCES (ARP) (1.25%)
- AEROACROPHOBIA- FEAR OF OPEN HIGH PLACES (AER) (3.75%)
- AGORAPHOBIA- FEAR OF OPEN SPACES OR OF BEING IN CROWDED (AGO) (6.67%)
- AILUROPHOBIA-FEAR OF CATS(AIL)(1.94%)
- ALTOPHOBIA- FEAR OF HEIGHTS (ALT) (1.81%)
- ANCRAOPHOBIA- FEAR OF WIND(ANEMOPHOBIA) (ANC)(2.50%)
- ATEPHOBIA- FEAR OF RUIN OR RUINS(ATE) (0.56%)
- CLAUSTROPHOBIA- FEAR OF CONFINED SPACES(CLAU)(0.83%)
- CLITHROPHOBIA OR CLEITHROPHOBIA- FEAR OF BEING ENCLOSED (CLITH) (1.11%)
- COIMETROPHOBIA- FEAR OF CEMETERIES (COIM)(4.03%)
- ENOCHLOPHOBIA- FEAR OF CROWDS (ENOCH)(1.81%)
- SPECTROPHOBIA – FEAR OF GHOSTS (GP)(3.61%)
- LALIOPHOBIA OR LALOPHOBIA- FEAR OF SPEAKING(LALI) (0.69%)
- SCIOPHOBIA SCIAPHOBIA- FEAR OF SHADOWS (SCIOP)(1.53%)

Smoking :- (See Figure 14)

- ✓ Smoking (13.33%)
- ✓ Gutka (1.39%)
- ✓ Alcohol (0.14%)
- ✓ Marijuna (0.14%)

Orphans of armed Conflict Total 442 (Aggregate)

Stress Disorders:- (See Figure 26)

- ➢ POST-TRAUMATIC STRESS DISORDER (PTSD) (24.66%)
- ➢ MAJOR DEPRESSION DISORDER OR CLINICAL DEPRESSION (MDD) (17.87%)
- ➢ CONVERSION DISORDER(CD) (7.01%)
- ➢ PANIC DISORDER (PD) (3.85%)
- ➢ ATTENTION DEFICIT HYPERACTIVITY DISORDER (ADHD OR ADHAD (2.26%)
- ➢ Female Hysteria(Hysteria) (2.26%)
- ➢ PARANOID PERSONALITY DISORDER (PPD) (1.13%)
- ➢ SCHIZOTYPAL PERSONALITY DISORDER (SPD) (0.45%)
- ➢ ANTISOCIAL PERSONALITY DISORDER (APD)) (0.45%)
- ➢ REACTIVE ATTACHME DISORDER (RAD) (0.45%)
- ➢ Dysthymia (1.58%)
- ➢ Eating Disorder (1.13%)

Orphans of Armed Conflict Total 442

Phobias:- (See Figure 27)

- ❖ ABLUTOPHOBIA- FEAR OF WASHING OR BATHING(ABL) (2.49%)
- ❖ ENTOMOPHOBIA- FEAR OF INSECTS. (ENT)(2.71%)
- ❖ ACHLUOPHOBIA- FEAR OF DARKNESS. (ACH)(1.81%)

- ACOUSTICOPHOBIA- FEAR OF NOISE (ACU) (1.36%)
- ACROPHOBIA- FEAR OF HEIGHTS (ACR)(5.66%)
- AEROPHOBIA- FEAR OF DRAFTS, AIR SWALLOWING, OR AIRBORNE NOXIOUS SUBSTANCES (ARP) (2.94%)
- AEROACROPHOBIA- FEAR OF OPEN HIGH PLACES (AER) (6.79%)
- AGORAPHOBIA- FEAR OF OPEN SPACES OR OF BEING IN CROWDED (AGO)(6.56%)
- AILUROPHOBIA-FEAR OF CATS(AIL)(3.85%)
- ALTOPHOBIA- FEAR OF HEIGHTS (ALT) (6.56%)
- ANCRAOPHOBIA- FEAR OF WIND(ANEMOPHOBIA) (ANC)(4.30%)
- CLAUSTROPHOBIA- FEAR OF CONFINED SPACES(CLAU)(5.43%)
- Clithrophobia or Cleithrophobia- Fear of being enclosed(CLITH)(3.62%)
- COIMETROPHOBIA- FEAR OF CEMETERIES (COIM)(10.18%)
- ENOCHLOPHOBIA- FEAR OF CROWDS (ENOCH)(4.30%)
- SPECTROPHOBIA – FEAR OF GHOSTS (GP) (3.62%)
- LALIOPHOBIA OR LALOPHOBIA- FEAR OF SPEAKING(LALI) (5.88%)
- POLITICOPHOBIA- FEAR OR ABNORMAL DISLIKE OF POLITICIANS (POLITI) (5.88%)
- SCIOPHOBIA SCIAPHOBIA- FEAR OF SHADOWS (SCIOP)(7.92%)

Orphans of Armed Conflict Total 442

Smoking :- (See Figure 28)

- ✓ Smoking (7.47%)
- ✓ Gutka (2.04%)
- ✓ Alcohol (0.45%)
- ✓ Marijuana (0.23%)

Notes

i) A study conducted by Irudayasamy (2006) showed that children who are orphans face many psychological disorders. At the age when they need much support from their parents and siblings to cope up with physical and emotional development, the loss of their parents make them more prone to psychological disorders.

ii) Curtis Committee reports and recommends that children without parental support should be raised in Foster homes, while as Lyle recommends that handicapped children were better-off with mental fitness when compared with those children without parental support who lived-in institutions or hostels [like that of ultramodern orphanages].

iii) A study conducted by Sudan (2010) highlighted the problems faced by children who migrated from Kashmir, the basic objective of the study was to understand the socio economic implications of armed conflict on misplaced migrant children and how they got affected under such conditions, to include their experience and understanding.

iv) Mufti Mohammad Saeed , the then Home Minister of India was instrumental for invoking AFSPA in the State of Jammu and Kashmir [impliedly] says a researcher, Anton Parlow in his study titled “Armed Conflict and Children's Health: The case of Kashmir,”dated:10/31/2012.

As, on December 8, 1989 , Friday, Dr. Rubaiya Saeed was kidnapped by JKLF members , the daughter of Mufti Mohammad Saeed, then the Home minister of India in the V. P. Singh government. The kidnappers demanded the release of five of their comrades in exchange for Rubaiya's release which include Sheikh Abdul Hameed, a JKLF “area commander” Ghulam Nabi Butt; Noor Muhammad Kalwal; Muhammed Altaf; and Javed Ahmed Zargar. The government accepted their demands and freed the jailed militants. Dr. Rubaiya Saeed was kidnapped within five days of her father becoming the first Muslim Minister for Home Affairs government of India. In Jan 30, 1999, Saturday, three JKLF militants Shoukat Ahmed Bakshi, Manzoor Ahmed Sofi and Mohammad Iqbal Gandroo were granted bail after 9 years, TADA court Presiding Officer, while granting bail directed that the accused be released on furnishing personal bail bonds of Rs 50,000 each with two sureties of like amount each. A case under Section 364 Ranbir Penal Code (RPC), Section 3 of TADA and Section 3/25 Arms Act was registered with Sadar police station, Srinagar on December 8, 1989. The case was later transferred to the CBI.

The unfortunate incident of kidnapping and killing of the then Kashmir University Vice Chancellor Mushir-ul-Haq, his private secretary Abdul Gani and Hindustan Machine Tools (HMT) General Manager H.L. Khera by Jammu Kashmir Students Liberation Front (JKSLF) in April 1990 took place, who demanded three jailed militants be released, the then Governor Jagmohan rejected the demand, following which all the three captives were killed. Although, a Terrorism and Disruptive Activities (TADA) court after 19 years acquitted Tahir Mir, Ghulam Qadir Mir, Shabir Ahmad Bhat, Abdul Aziz Zargar, Mohammed Sadiq Rather, Mushtaq Ahmad Khan and Mohammad Salim Zargar.

v) This includes murder, kidnapping, bomb explosions, sexual abuse, and torture by militants/ Indian security forces. Moreover, there are many examples in which civilians were shot during cross-fires and in some cases women were sexually abused by security force personnel and some got disappeared in security custody.

vi) Although, some neutral commentators believe that the orchestrated migration of Kashmiri Pandits was done with the motive to give armed resistance movement of Kashmir, a communal twinge; but, there were some incidents of Pandit assassinations, largely in 1990, carried out by militants, some Kashmiri Pandit organisations like Panun Kashmir has vehemently blamed mainly JKLF for the killing of Pandits in 1990, presently, the migrant Kashmiri Pandit population is almost 0.45 million, who are internally displaced , the radical organisations of Kashmiri Pandits put the figures more.

vii) The militancy in Kashmir is also embedded in the Indian-Pakistani conflict over the territory of Jammu and Kashmir resulting in three wars (1947, 1965, and 1999) besides equal number of nonconventional wars.

viii) This can be viewed by the fact that almost all the monitory support to pro-Independence armed resistance organisations was withdrawn and as a result on

21st May 1994,Saturday ,Jammu and Kashmir Liberation Front announced unilateral ceasefire ,though there was a large scale disagreement among the rank and file of the organisation , even in December 2012 or January 2013, JKLF led by Aman Ullah Khan, made a paradigm change to the organisation's Insignia/logo by replacing gun with the spike of wheat giving an impression that organisation believes in development/progress with a main focus on peaceful political struggle and wants solution of Kashmir peacefully, besides sword is also in Insignia/Logo, messaging indigenous resistance with an objective to believe in National Independence .

ix) Indian Security Agencies blame militants for these horrendous acts, while as militants organisations of Kashmir maintain that Indian agencies are behind such pogroms.

a) In one classical incident, on 20th March 2000, Monday evening 15–17 unidentified gunmen, dressed in Indian army fatigues, entered the village of Chattisinghpora, located in Anantnag district. They ordered all of the Sikh men and boys to assemble at the village Gurdwara, and systematically shot and killed 34 of them. The massacre, which took place on the eve of U.S. President Bill Clinton's visit to the Subcontinent, was widely condemned by both the Indian and Pakistani governments, as well as the leaders of the Kashmiri separatist movement. Five days after the events at Chattisinghpora, on 25th March 2000, Saturday , Indian military forces killed five men in Pathribal village of Anantnag district, claiming that the victims were the "foreign militants" responsible for the attacks. On 19 March 2012, Monday. The CBI (central Bureau of Investigation) told the Supreme Court of India that the fake encounter at Pathribal in Jammu and Kashmir 12 years ago in which seven people were killed by Army personnel "were cold-blooded murders and the accused officials deserve to be meted out exemplary punishment." Senior counsel Ashok Bhan told a special bench of justices B S Chauhan and Swatanter Kumar that no prior sanction was required for prosecuting the Army officials and the need to ensure "public confidence in the rule of law and dispensation of justice" warranted their prosecution. "Our investigations have revealed it was a fake encounter and cold-blooded.

Meanwhile a youth namely Mohammad Yaqoob Wagey of the same area was arrested by security agencies and claimed by them that villagers recognised Wagey among the killers a "guide" from a neighbouring village, later on Yaqoob was acquitted by local court but after several years of rigorous imprisonment , at the time of arrest he was a student of 12th class , now he is a wandering boy and suffering from PTSD, even his confinement of innocence has not been compensated by the State Government .

Though, Army on Thursday, 23rd of January 2014, closed the Pathribal fake encounter case saying that the evidence recorded could not establish prime facie charges against any of the accused persons.

"The evidence recorded could not establish a prime facie case against any of the accused persons," a defence spokesman said in Jammu, adding that, however, it was "clearly established that it (the Pathribal encounter) was a joint operation by police and the Army based on specific intelligence".

"The case has been closed by Army authorities and intimation given to the Court of the judicial magistrate in Srinagar," the spokesman said.

Jammu Kashmir Chief Minister, Omar Abdullah, on Friday 24th of January 2014, expressed extreme displeasure over the closure of Pathribal fake encounter case and reiterated that he would direct the State's Law Department to explore options available to the government. Peoples Democratic Party (PDP), the biggest mainstream political party termed the closure of Pathribal case by Army as miscarriage of justice, while as separatist[pro-resistance] leaders of Kashmir, unanimously said that they were not surprised by the Army's decision to close Pathribal fake encounter case, as already they have not pinned any hope on the Army court. Conversely, Amnesty International on Friday 24th of January 2014, said, "Given the evidence that existed against [these] soldiers , the Army's decision to conduct a new probe into the case is baffling." "But perhaps it isn't surprising that the Army, after deciding to investigate its own alleged abuses, has given itself a clean chit," Amnesty said in its statement.

b) In early February 2007, crowds of men and women took to the streets in Kashmir Valley, shouting anti-government slogans and carrying wooden coffin sin the air as they made their way through the thoroughfares and byways of the capital city of Srinagar. The scene recalled the massive crowd demonstration since January 1990 that marked the onset of the region's conflict what has alternately been called a secessionist movement, an insurgency [militancy], and a low-intensity war. At that time, Kashmiri men and women shuttered their shops and joined massive public demonstrations in Srinagar and other towns in Kashmir Valley in open support for the movement for 'Azadi' [Freedom], or independence from the Indian state. Through these demonstrations, the Kashmiri people were expressing their demand for self-determination in response to the Indian state's systematic pattern of disenfranchisement and denial of rights in the region. Kashmiris remember that period as a time of great excitement but also great restlessness and apprehension, with an atmosphere of uncertainty that carried the promise but also the threat of change.

Some 17 years after those mass demonstrations, Kashmiri crowds again took to the streets in a collective expression of anger against the denial of justice, in this case, the longstanding pattern of state security forces killing innocent civilians in fake encounters and burying them under the name of foreign, typically Pakistani, militants. The protests came in the wake of an explosive turn of events in which police officers, under pressure from families and local human rights non-governmental organisations (NGOs), publicly exhumed a series of bodies identified as foreign militants from several graveyards in Kashmir and performed DNA tests to ascertain their true identities. The tests concluded that the bodies were not those of the foreign militants whose names they had been given in death, but rather Kashmiri civilians. A carpenter, a perfume seller, a shopkeeper, an imam, and a state employee whose families had been desperately searching for them for months. Protesters carried these bodies, riddled with bullet holes, through the streets in their coffins as they urged the government to bring an end to extrajudicial killings through fake encounters and deliver justice by resolving the thousands of cases of enforced disappearances throughout Kashmir Valley. The terms fake encounters, false encounters, and encounter killings are widely used in their English forms throughout Kashmir Valley to refer to the staged gun battles that constitute a distinctive cultural practice of state violence in the region. Since 1990, Kashmiri regional newspapers have regularly run stories, based on government-issued press notes, about young Kashmiri men who were killed in an encounter between militants and troops. Kashmiris widely acknowledge that these stories describe, not instances of individuals killed while engaging in gun battle with security forces, but rather episodes of extrajudicial executions of individuals who for one reason or another were targeted for death. These killings may take place after the victim has been detained in official custody for at least a short period prior to death, or they may take place on the streets, prior to detention, as security forces or police officers or paramilitary personnel kill the individual at the moment of observation or apprehension. The extrajudicial killing is then followed by the official claim that the victim died in a legitimate military encounter with police or army forces. In some cases, the victim's identity is altered as the body is presented, along with an array of weapons, ammunitions and other evidence of guilt ostensibly recovered from his possession, under the false name of a foreign, typically Pakistani, infiltrator, thus creating patterns of disappearances as victim's family members search for information about their loved ones who have been buried under false names.

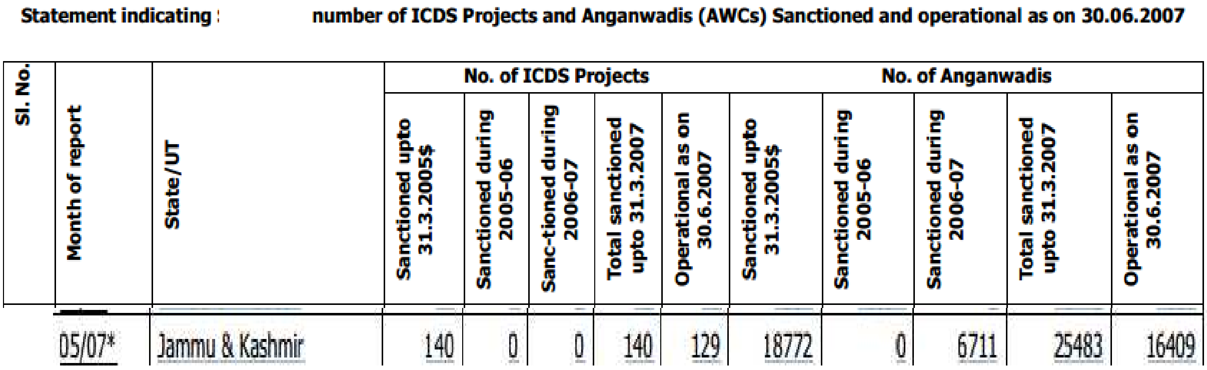
Abdul Rahman Paddar, a carpenter of Larnoo Kokernag in South Kashmir had gone missing on December 8 last year from Batamaloo locality of Srinagar. His family lodged complaint with Police, who during investigations stumbled on startling evidence that Paddar had been killed in a fake encounter by SOG and had been buried as a Pakistani commander Abu Hafeez of Lashkar-e-Toiba in Sumbal. The arrest and interrogation of two SOG men, ASI Farooq Ahmad Guddu and senior grade constable Farooq Ahmad Paddar involved in the carpenter's killing, led the police to the shocking exposure of four other persons having been killed in the same fashion.

('Fake encounter case. . .' 2007)

Source: Haley Duschinski, Reproducing Regimes of Impunity: Fake Encounters and the Informalization of Violence in Kashmir Valley, Taylor & Francis, 2010, pp110-111.

x) Stunted is defined as two standard deviations less than the reference population.
xi) This means lower in absolute values because the average HAZ score is negative.

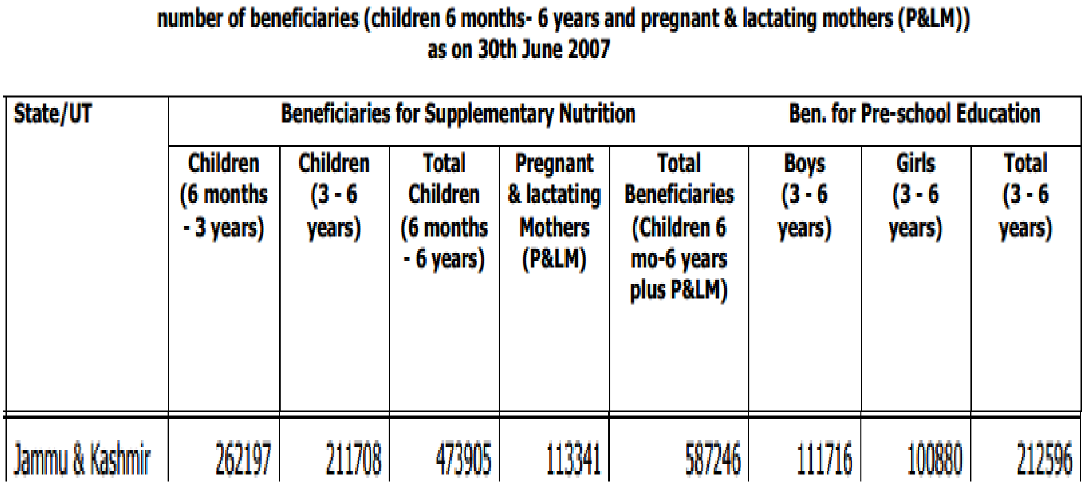
Appendix I



Statement indicating : **number of ICDS Projects and Anganwadis (AWCs) Sanctioned and operational as on 30.06.2007**

Sl. No.	Month of report	State/UT	No. of ICDS Projects					No. of Anganwadis				
			Sanctioned upto 31.3.2005$	Sanctioned during 2005-06	Sanc-tioned during 2006-07	Total sanctioned upto 31.3.2007	Operational as on 30.6.2007	Sanctioned upto 31.3.2005$	Sanctioned during 2005-06	Sanctioned during 2006-07	Total sanctioned upto 31.3.2007	Operational as on 30.6.2007
	05/07*	Jammu & Kashmir	140	0	0	140	129	18772	0	6711	25483	16409

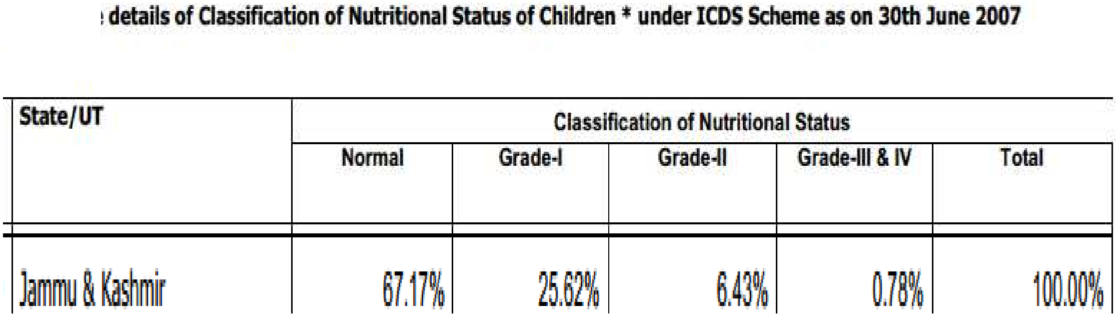
Source: Ministry of Women and Child Development Government of India*



number of beneficiaries (children 6 months- 6 years and pregnant & lactating mothers (P&LM)) as on 30th June 2007

State/UT	Beneficiaries for Supplementary Nutrition					Ben. for Pre-school Education		
	Children (6 months - 3 years)	Children (3 - 6 years)	Total Children (6 months - 6 years)	Pregnant & lactating Mothers (P&LM)	Total Beneficiaries (Children 6 mo-6 years plus P&LM)	Boys (3 - 6 years)	Girls (3 - 6 years)	Total (3 - 6 years)
Jammu & Kashmir	262197	211708	473905	113341	587246	111716	100880	212596

Source: Ministry of Women and Child Development Government of India*



: details of Classification of Nutritional Status of Children * under ICDS Scheme as on 30th June 2007

State/UT	Classification of Nutritional Status				
	Normal	Grade-I	Grade-II	Grade-III & IV	Total
Jammu & Kashmir	67.17%	25.62%	6.43%	0.78%	100.00%

Source: Ministry of Women and Child Development Government of India*

Appendix II

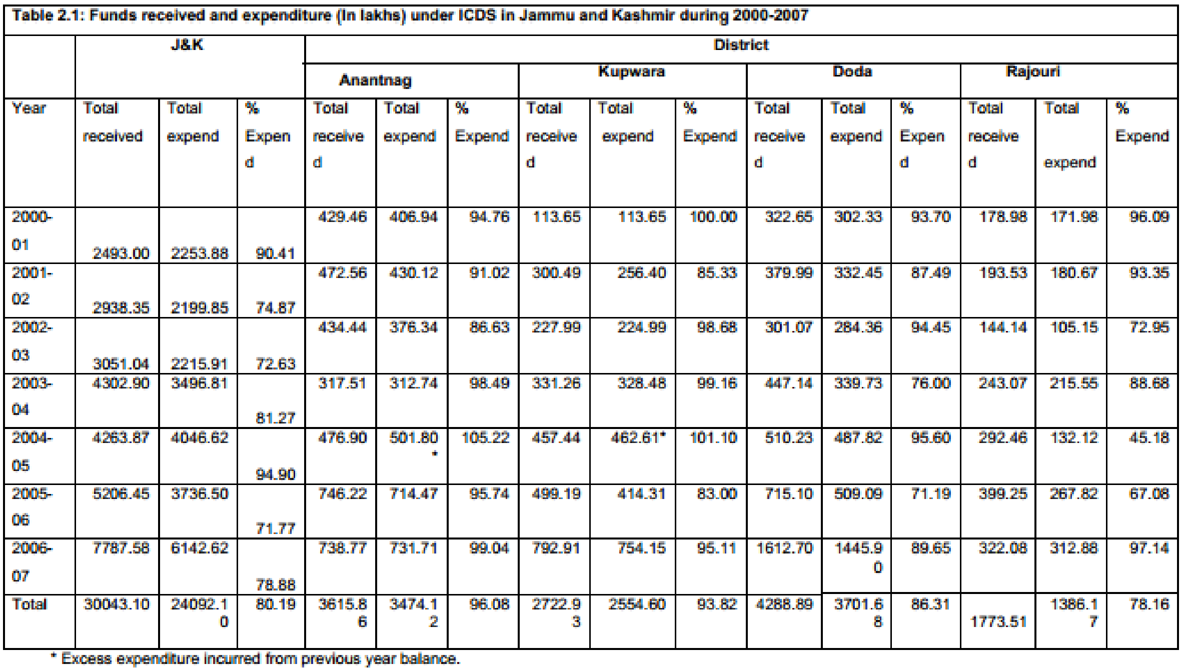


Table 2.1: Funds received and expenditure (In lakhs) under ICDS in Jammu and Kashmir during 2000-2007

	J&K			District											
				Anantnag			Kupwara			Doda			Rajouri		
Year	Total received	Total expend	% Expend	Total received	Total expend	% Expend	Total received	Total expend	% Expend	Total received	Total expend	% Expend	Total received	Total expend	% Expend
2000-01	2493.00	2253.88	90.41	429.46	406.94	94.76	113.65	113.65	100.00	322.65	302.33	93.70	178.98	171.98	96.09
2001-02	2938.35	2199.85	74.87	472.56	430.12	91.02	300.49	256.40	85.33	379.99	332.45	87.49	193.53	180.67	93.35
2002-03	3051.04	2215.91	72.63	434.44	376.34	86.63	227.99	224.99	98.68	301.07	284.36	94.45	144.14	105.15	72.95
2003-04	4302.90	3496.81	81.27	317.51	312.74	98.49	331.26	328.48	99.16	447.14	339.73	76.00	243.07	215.55	88.68
2004-05	4263.87	4046.62	94.90	476.90	501.80*	105.22	457.44	462.61*	101.10	510.23	487.82	95.60	292.46	132.12	45.18
2005-06	5206.45	3736.50	71.77	746.22	714.47	95.74	499.19	414.31	83.00	715.10	509.09	71.19	399.25	267.82	67.08
2006-07	7787.58	6142.62	78.88	738.77	731.71	99.04	792.91	754.15	95.11	1612.70	1445.90	89.65	322.08	312.88	97.14
Total	30043.10	24092.10	80.19	3615.86	3474.12	96.08	2722.93	2554.60	93.82	4288.89	3701.68	86.31	1773.51	1386.17	78.16

* Excess expenditure incurred from previous year balance.

Source: Planning Commission of India, New Delhi*

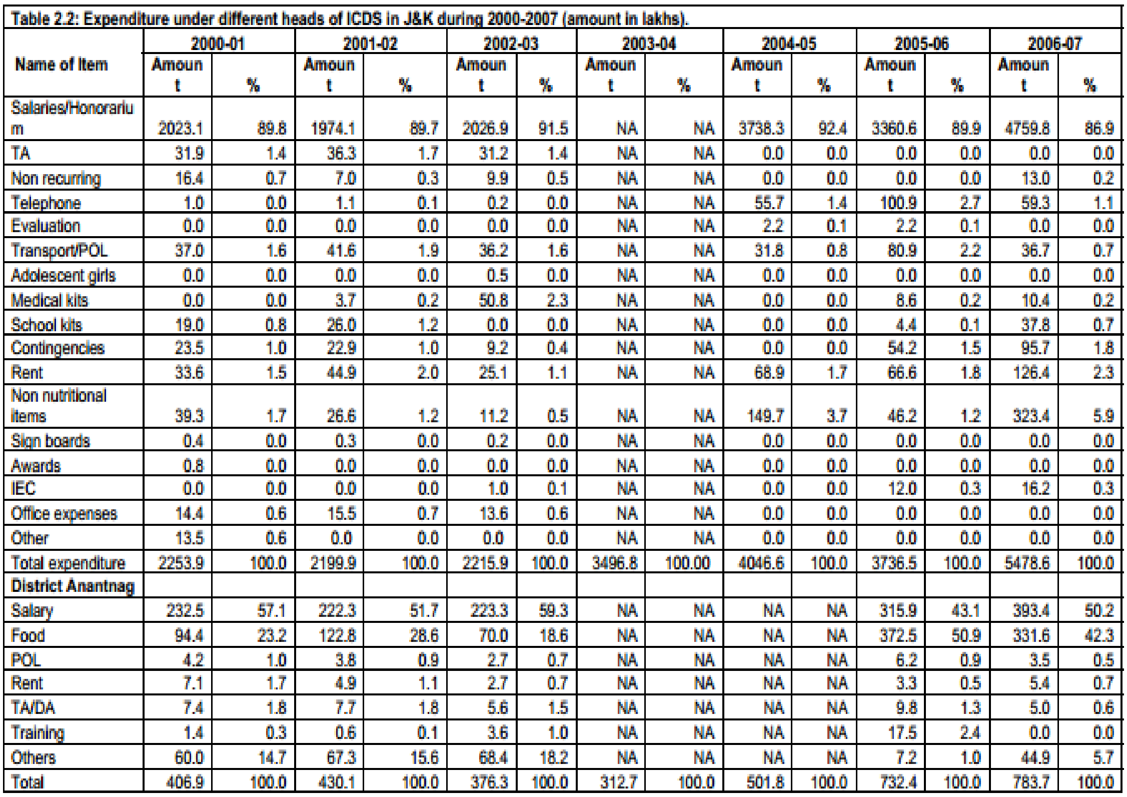
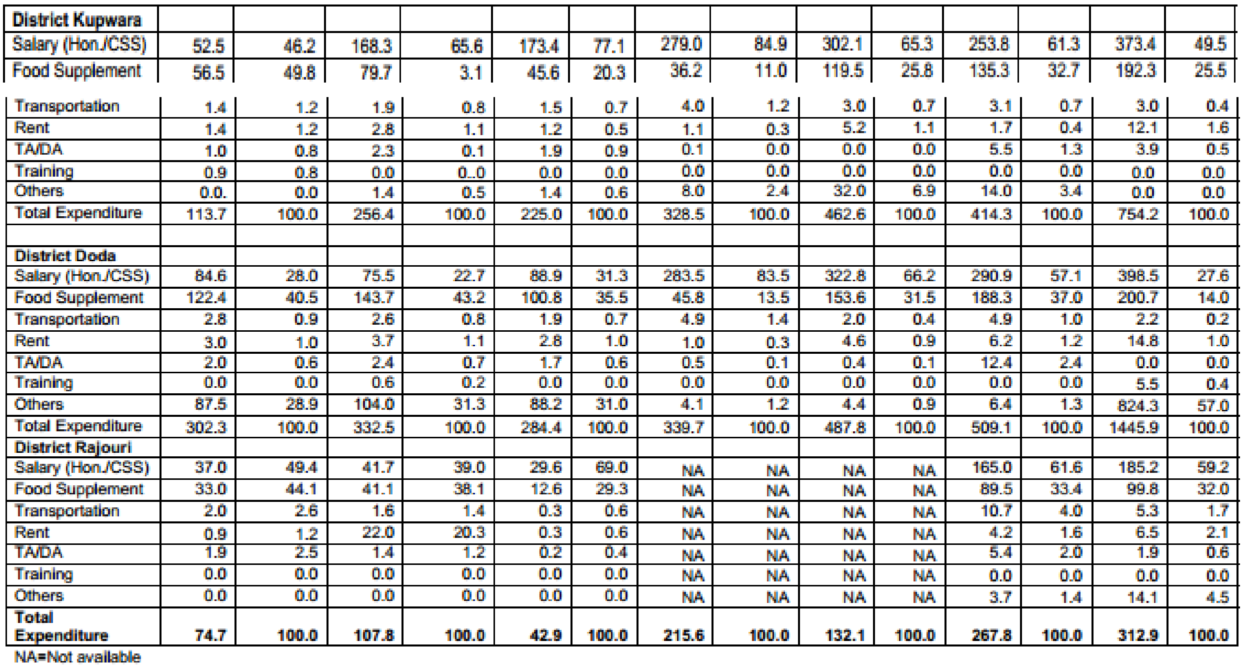


Table 2.2: Expenditure under different heads of ICDS in J&K during 2000-2007 (amount in lakhs).

Name of Item	2000-01		2001-02		2002-03		2003-04		2004-05		2005-06		2006-07	
	Amount	%	Amount	%	Amount	%	Amount	%	Amount	%	Amount	%	Amount	%
Salaries/Honorarium	2023.1	89.8	1974.1	89.7	2026.9	91.5	NA	NA	3738.3	92.4	3360.6	89.9	4759.8	86.9
TA	31.9	1.4	36.3	1.7	31.2	1.4	NA	NA	0.0	0.0	0.0	0.0	0.0	0.0
Non recurring	16.4	0.7	7.0	0.3	9.9	0.5	NA	NA	0.0	0.0	0.0	0.0	13.0	0.2
Telephone	1.0	0.0	1.1	0.1	0.2	0.0	NA	NA	55.7	1.4	100.9	2.7	59.3	1.1
Evaluation	0.0	0.0	0.0	0.0	0.0	0.0	NA	NA	2.2	0.1	2.2	0.1	0.0	0.0
Transport/POL	37.0	1.6	41.6	1.9	36.2	1.6	NA	NA	31.8	0.8	80.9	2.2	36.7	0.7
Adolescent girls	0.0	0.0	0.0	0.0	0.5	0.0	NA	NA	0.0	0.0	0.0	0.0	0.0	0.0
Medical kits	0.0	0.0	3.7	0.2	50.8	2.3	NA	NA	0.0	0.0	8.6	0.2	10.4	0.2
School kits	19.0	0.8	26.0	1.2	0.0	0.0	NA	NA	0.0	0.0	4.4	0.1	37.8	0.7
Contingencies	23.5	1.0	22.9	1.0	9.2	0.4	NA	NA	0.0	0.0	54.2	1.5	95.7	1.8
Rent	33.6	1.5	44.9	2.0	25.1	1.1	NA	NA	68.9	1.7	66.6	1.8	126.4	2.3
Non nutritional items	39.3	1.7	26.6	1.2	11.2	0.5	NA	NA	149.7	3.7	46.2	1.2	323.4	5.9
Sign boards	0.4	0.0	0.3	0.0	0.2	0.0	NA	NA	0.0	0.0	0.0	0.0	0.0	0.0
Awards	0.8	0.0	0.0	0.0	0.0	0.0	NA	NA	0.0	0.0	0.0	0.0	0.0	0.0
IEC	0.0	0.0	0.0	0.0	1.0	0.1	NA	NA	0.0	0.0	12.0	0.3	16.2	0.3
Office expenses	14.4	0.6	15.5	0.7	13.6	0.6	NA	NA	0.0	0.0	0.0	0.0	0.0	0.0
Other	13.5	0.6	0.0	0.0	0.0	0.0	NA	NA	0.0	0.0	0.0	0.0	0.0	0.0
Total expenditure	2253.9	100.0	2199.9	100.0	2215.9	100.0	3496.8	100.00	4046.6	100.0	3736.5	100.0	5478.6	100.0
District Anantnag														
Salary	232.5	57.1	222.3	51.7	223.3	59.3	NA	NA	NA	NA	315.9	43.1	393.4	50.2
Food	94.4	23.2	122.8	28.6	70.0	18.6	NA	NA	NA	NA	372.5	50.9	331.6	42.3
POL	4.2	1.0	3.8	0.9	2.7	0.7	NA	NA	NA	NA	6.2	0.9	3.5	0.5
Rent	7.1	1.7	4.9	1.1	2.7	0.7	NA	NA	NA	NA	3.3	0.5	5.4	0.7
TA/DA	7.4	1.8	7.7	1.8	5.6	1.5	NA	NA	NA	NA	9.8	1.3	5.0	0.6
Training	1.4	0.3	0.6	0.1	3.6	1.0	NA	NA	NA	NA	17.5	2.4	0.0	0.0
Others	60.0	14.7	67.3	15.6	68.4	18.2	NA	NA	NA	NA	7.2	1.0	44.9	5.7
Total	406.9	100.0	430.1	100.0	376.3	100.0	312.7	100.0	501.8	100.0	732.4	100.0	783.7	100.0

Source: Planning Commission of India, New Delhi*



District Kupwara														
Salary (Hon./CSS)	52.5	46.2	168.3	65.6	173.4	77.1	279.0	84.9	302.1	65.3	253.8	61.3	373.4	49.5
Food Supplement	56.5	49.8	79.7	3.1	45.6	20.3	36.2	11.0	119.5	25.8	135.3	32.7	192.3	25.5
Transportation	1.4	1.2	1.9	0.8	1.5	0.7	4.0	1.2	3.0	0.7	3.1	0.7	3.0	0.4
Rent	1.4	1.2	2.8	1.1	1.2	0.5	1.1	0.3	5.2	1.1	1.7	0.4	12.1	1.6
TA/DA	1.0	0.8	2.3	0.1	1.9	0.9	0.1	0.0	0.0	0.0	5.5	1.3	3.9	0.5
Training	0.9	0.8	0.0	0..0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
Others	0.0.	0.0	1.4	0.5	1.4	0.6	8.0	2.4	32.0	6.9	14.0	3.4	0.0	0.0
Total Expenditure	113.7	100.0	256.4	100.0	225.0	100.0	328.5	100.0	462.6	100.0	414.3	100.0	754.2	100.0
District Doda														
Salary (Hon./CSS)	84.6	28.0	75.5	22.7	88.9	31.3	283.5	83.5	322.8	66.2	290.9	57.1	398.5	27.6
Food Supplement	122.4	40.5	143.7	43.2	100.8	35.5	45.8	13.5	153.6	31.5	188.3	37.0	200.7	14.0
Transportation	2.8	0.9	2.6	0.8	1.9	0.7	4.9	1.4	2.0	0.4	4.9	1.0	2.2	0.2
Rent	3.0	1.0	3.7	1.1	2.8	1.0	1.0	0.3	4.6	0.9	6.2	1.2	14.8	1.0
TA/DA	2.0	0.6	2.4	0.7	1.7	0.6	0.5	0.1	0.4	0.1	12.4	2.4	0.0	0.0
Training	0.0	0.0	0.6	0.2	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	5.5	0.4
Others	87.5	28.9	104.0	31.3	88.2	31.0	4.1	1.2	4.4	0.9	6.4	1.3	824.3	57.0
Total Expenditure	302.3	100.0	332.5	100.0	284.4	100.0	339.7	100.0	487.8	100.0	509.1	100.0	1445.9	100.0
District Rajouri														
Salary (Hon./CSS)	37.0	49.4	41.7	39.0	29.6	69.0	NA	NA	NA	NA	165.0	61.6	185.2	59.2
Food Supplement	33.0	44.1	41.1	38.1	12.6	29.3	NA	NA	NA	NA	89.5	33.4	99.8	32.0
Transportation	2.0	2.6	1.6	1.4	0.3	0.6	NA	NA	NA	NA	10.7	4.0	5.3	1.7
Rent	0.9	1.2	22.0	20.3	0.3	0.6	NA	NA	NA	NA	4.2	1.6	6.5	2.1
TA/DA	1.9	2.5	1.4	1.2	0.2	0.4	NA	NA	NA	NA	5.4	2.0	1.9	0.6
Training	0.0	0.0	0.0	0.0	0.0	0.0	NA	NA	NA	NA	0.0	0.0	0.0	0.0
Others	0.0	0.0	0.0	0.0	0.0	0.0	NA	NA	NA	NA	3.7	1.4	14.1	4.5
Total Expenditure	**74.7**	**100.0**	**107.8**	**100.0**	**42.9**	**100.0**	**215.6**	**100.0**	**132.1**	**100.0**	**267.8**	**100.0**	**312.9**	**100.0**

NA=Not available

Table 2.2 a Source: Planning Commission of India, New Delhi*

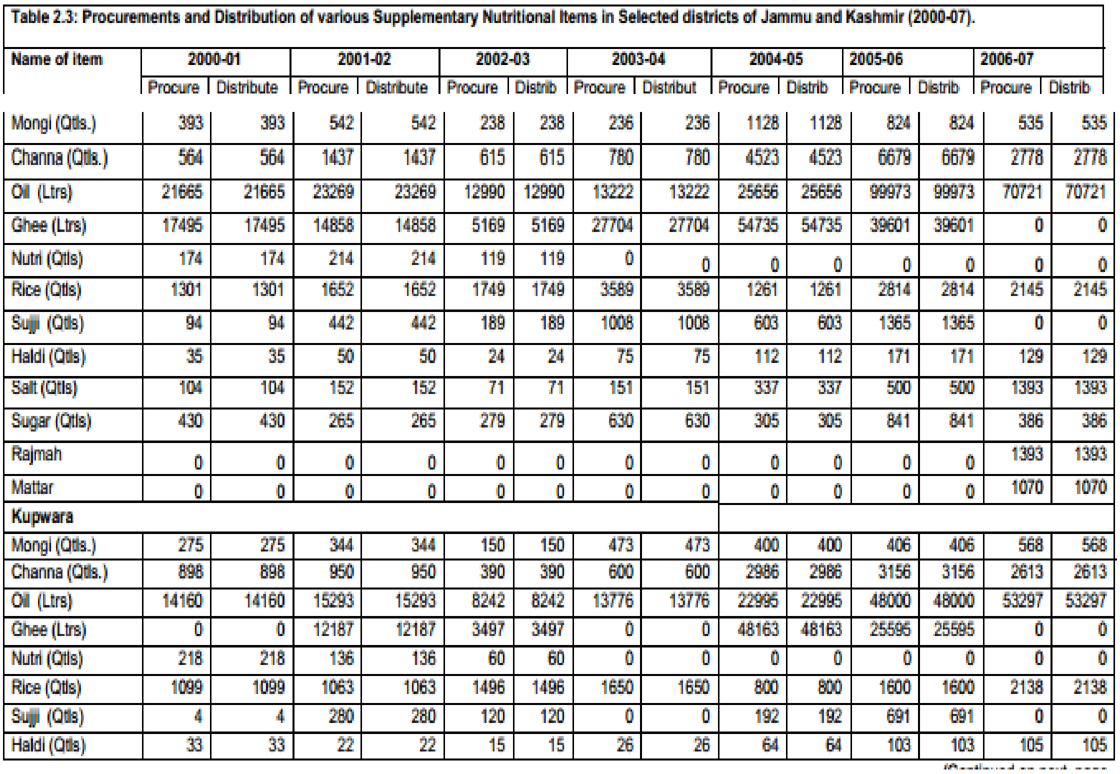


Table 2.3: Procurements and Distribution of various Supplementary Nutritional Items in Selected districts of Jammu and Kashmir (2000-07).

Name of item	**2000-01**		**2001-02**		**2002-03**		**2003-04**		**2004-05**		**2005-06**		**2006-07**	
	Procure	Distribute	Procure	Distribute	Procure	Distrib	Procure	Distribut	Procure	Distrib	Procure	Distrib	Procure	Distrib
Mongi (Qtls.)	393	393	542	542	238	238	236	236	1128	1128	824	824	535	535
Channa (Qtls.)	564	564	1437	1437	615	615	780	780	4523	4523	6679	6679	2778	2778
Oil (Ltrs)	21665	21665	23269	23269	12990	12990	13222	13222	25656	25656	99973	99973	70721	70721
Ghee (Ltrs)	17495	17495	14858	14858	5169	5169	27704	27704	54735	54735	39601	39601	0	0
Nutri (Qtls)	174	174	214	214	119	119	0	0	0	0	0	0	0	0
Rice (Qtls)	1301	1301	1652	1652	1749	1749	3589	3589	1261	1261	2814	2814	2145	2145
Sujji (Qtls)	94	94	442	442	189	189	1008	1008	603	603	1365	1365	0	0
Haldi (Qtls)	35	35	50	50	24	24	75	75	112	112	171	171	129	129
Salt (Qtls)	104	104	152	152	71	71	151	151	337	337	500	500	1393	1393
Sugar (Qtls)	430	430	265	265	279	279	630	630	305	305	841	841	386	386
Rajmah	0	0	0	0	0	0	0	0	0	0	0	0	1393	1393
Mattar	0	0	0	0	0	0	0	0	0	0	0	0	1070	1070
Kupwara														
Mongi (Qtls.)	275	275	344	344	150	150	473	473	400	400	406	406	568	568
Channa (Qtls.)	898	898	950	950	390	390	600	600	2986	2986	3156	3156	2613	2613
Oil (Ltrs)	14160	14160	15293	15293	8242	8242	13776	13776	22995	22995	48000	48000	53297	53297
Ghee (Ltrs)	0	0	12187	12187	3497	3497	0	0	48163	48163	25595	25595	0	0
Nutri (Qtls)	218	218	136	136	60	60	0	0	0	0	0	0	0	0
Rice (Qtls)	1099	1099	1063	1063	1496	1496	1650	1650	800	800	1600	1600	2138	2138
Sujji (Qtls)	4	4	280	280	120	120	0	0	192	192	691	691	0	0
Haldi (Qtls)	33	33	22	22	15	15	26	26	64	64	103	103	105	105

Source: Planning Commission of India, New Delhi*

Continued from last page

Salt (Qtls)	83	83	96	96	45	45	78	78	320	320	348	348	293	293
Sugar (Qtls)	0	0	169	169	168	168	0	0	183	183	600	600	0	0
Peas	0	0	0	0	0	0	0	0	0	0	0	0	535	535
Rajmah	0	0	0	0	0	0	0	0	0	0	0	0	8599	8599
Doda														
Mongi (Qtls.)	347	347	387	387	179	179	288	288	854	854	1172	1172	1181	1181
Channa (Qtls.)	451	451	1036	1036	462	462	465	465	2861	2861	3068	3068	4130	4130
Oil (Ltrs)	174	174	18956	18956	9816	9816	8935	8935	36645	36645	54188	54188	52590	52590
Ghee (Ltrs)	69	69	14955	14955	3983	3983	3573	3573	38614	38614	0	0	0	0
Nutri (Qtls)	278	278	173	173	89	89	0	0	0	0	0	0	0	0
Rice (Qtls)	1389	1389	1465	1465	1890	1890	536	536	1830	1830	2087	2087	3406	3406
Sujji (Qtls)	278	278	334	334	142	142	143	143	675	675	0	0	0	0
Haldi (Qtls)	35	35	44	44	18	18	29	29	80	80	96	96	0	0
Salt (Qtls)	102	102	118	118	54	54	36	36	256	256	274	274	0	0
Sugar (Qtls)	173	173	196	196	200	200	89	89	270	270	0	0	0	0
Rajouri														
Mongi (Qtls.)	188	188	235	235	235	235	308	308	274	274	NA	NA	403	403
Channa (Qtls.)	244	244	636	636	618	618	533	533	710	710	NA	NA	2625	2625
Oil (Ltrs)	95	95	9685	9685	9573	9573	10256	10256	32820	32820	NA	NA	35886	35886
Ghee (Ltrs)	3759	3759	6804	6804	7111	7111	4102	4102	12581	12581	NA	NA	0	0
Nutri (Qtls)	150	150	100	100	93	93	0	0	0	0	NA	NA	0	0
Rice (Qtls)	752	752	662	662	717	717	308	308	274	274	NA	NA	0	0
Sujji (Qtls)	150	150	190	190	191	191	164	164	269	269	NA	NA	0	0
Haldi (Qtls)	27	27	20	20	22	22	33	33	22	22	NA	NA	59	59
Salt (Qtls)	27	27	65	65	66	66	41	41	66	66	NA	NA	3	3
Sugar (Qtls)	94	94	107	107	115	115	51	51	68	68	NA	NA	0	0

NA=Not Available

Tab.2.3a Source : Planning Commission of India , New Delhi*

Table 2.4: Number of ICDS projects and Anganwadi Centres Sanctioned and Operational in Jammu and Kashmir, 2003-2007.

	J&K		Anantnag		Kupwara		Doda		Rajouri	
Year	Sanctioned	Opera	Sanctioned	Opera	Sanctioned	Opera	Sanctioned	Opera	Sanctioned	Opera
ICDS Projects										
2003-04	121	121	10	8	8	3	14	6	7	5
2004-05	140	121	10	8	8	3	14	6	7	5
2005-06	140	140	13	8	11	6	19	14	7	6
2006-07	140	140	13	8	11	6	19	14	7	6
Anganwadi Centres										
2003-04	11955	10392	1261	1261	800	800	1010	953	547	547
2004-05	18772	10398	2145	NA	1439	NA	1703	NA	932	NA
2005-06	18772	16942	2145	NA	1439	NA	1703	NA	932	NA
2006-07	18772	18043	2145	2145	1439	1439	1703	1703	932	559

Table 2.5 A: Staff strength of ICDS Project Staff in Jammu and Kashmir -2003-2004.

	J&K		Anantnag		Kupwara		Doda		Rajouri	
Designation	Sanctioned	in position	Sanctioned	in position	Sanctioned	in position	Sanctioned	in position	Sanctioned	in position
Programme Officers	9	8	1	1	1	1	1	1	1	0
CDPO	120	106	10	8	8	3	14	6	7	5
ACDPOs	21	20	4	4	5	2	NA	NA	NA	NA
Section Officers	NA	NA	NA	NA	1	1	NA	NA	NA	NA
Head Assistants	19	19	1	1	1	1	3	3	NA	NA
Sr. Assistants	127	127	11	11	0	0	NA	NA	0	0
Supervisors	529	390	65	39	43	11	50	15	18	6
Clerks/typists	153	153	15	15	14	14	29	25	7	6
Peon	146	146	15	15	9	9	15	15	7	1
Drivers	131	131	11	11	19	19	15	12	7	7
Statistical Assistants	107	107	8	8	7	3	12	6	7	7
Anganwadi Worker	10325	10325	1261	1261	800	800	1010	953	547	547
Anganwadi Helper	10325	10325	1261	1261	800	800	1010	953	547	547
Helpers to Supervisors	529	529	NA	NA	NA	NA	NA	NA	NA	NA

NA=Not available

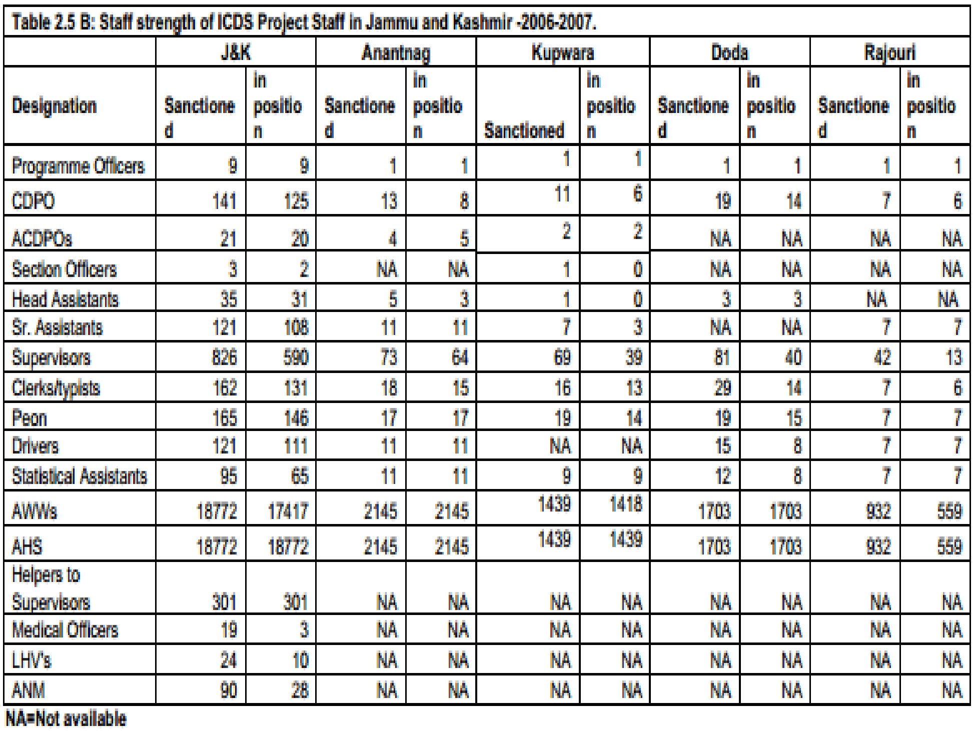


Table 2.5 B: Staff strength of ICDS Project Staff in Jammu and Kashmir -2006-2007.

	J&K		Anantnag		Kupwara		Doda		Rajouri	
Designation	Sanctioned	in position	Sanctioned	in position	Sanctioned	in position	Sanctioned	in position	Sanctioned	in position
Programme Officers	9	9	1	1	1	1	1	1	1	1
CDPO	141	125	13	8	11	6	19	14	7	6
ACDPOs	21	20	4	5	2	2	NA	NA	NA	NA
Section Officers	3	2	NA	NA	1	0	NA	NA	NA	NA
Head Assistants	35	31	5	3	1	0	3	3	NA	NA
Sr. Assistants	121	108	11	11	7	3	NA	NA	7	7
Supervisors	826	590	73	64	69	39	81	40	42	13
Clerks/typists	162	131	18	15	16	13	29	14	7	6
Peon	165	146	17	17	19	14	19	15	7	7
Drivers	121	111	11	11	NA	NA	15	8	7	7
Statistical Assistants	95	65	11	11	9	9	12	8	7	7
AWWs	18772	17417	2145	2145	1439	1418	1703	1703	932	559
AHS	18772	18772	2145	2145	1439	1439	1703	1703	932	559
Helpers to Supervisors	301	301	NA	NA	NA	NA	NA	NA	NA	NA
Medical Officers	19	3	NA	NA	NA	NA	NA	NA	NA	NA
LHV's	24	10	NA	NA	NA	NA	NA	NA	NA	NA
ANM	90	28	NA	NA	NA	NA	NA	NA	NA	NA

NA=Not available

Source: Planning Commission of India, New Delhi*

Source: Planning Commission of India , New Delhi

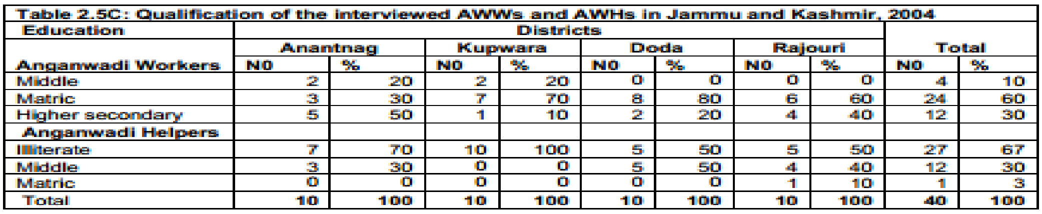


Table 2.5C: Qualification of the interviewed AWWs and AWHs in Jammu and Kashmir, 2004

Education	Districts									
	Anantnag		Kupwara		Doda		Rajouri		Total	
Anganwadi Workers	N0	%	N0	%	N0	%	N0	%	N0	%
Middle	2	20	2	20	0	0	0	0	4	10
Matric	3	30	7	70	8	80	6	60	24	60
Higher secondary	5	50	1	10	2	20	4	40	12	30
Anganwadi Helpers										
Illiterate	7	70	10	100	5	50	5	50	27	67
Middle	3	30	0	0	5	50	4	40	12	30
Matric	0	0	0	0	0	0	1	10	1	3
Total	10	100	10	100	10	100	10	100	40	100

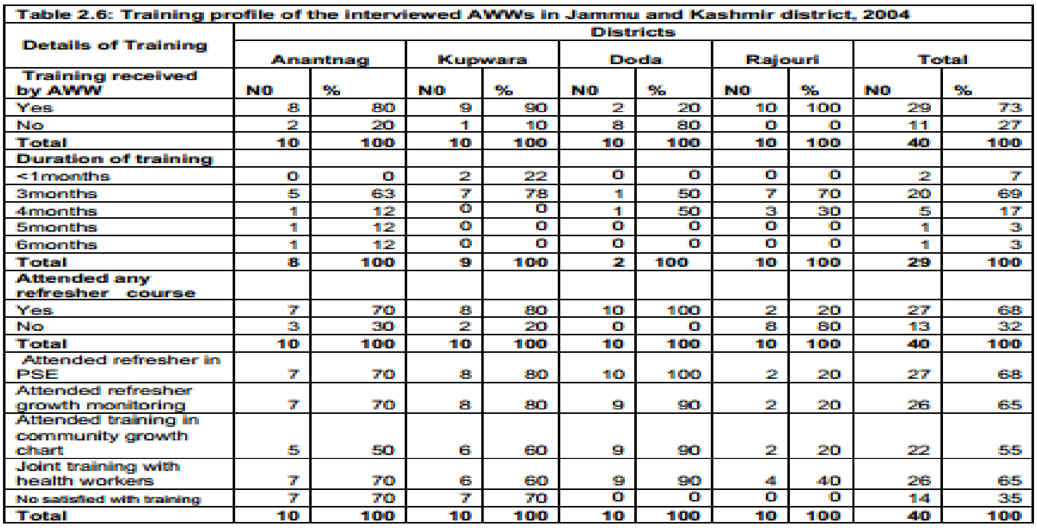


Table 2.6: Training profile of the interviewed AWWs in Jammu and Kashmir district, 2004

Details of Training	Districts									
	Anantnag		Kupwara		Doda		Rajouri		Total	
Training received by AWW	N0	%	N0	%	N0	%	N0	%	N0	%
Yes	8	80	9	90	2	20	10	100	29	73
No	2	20	1	10	8	80	0	0	11	27
Total	10	100	10	100	10	100	10	100	40	100
Duration of training										
<1months	0	0	2	22	0	0	0	0	2	7
3months	5	63	7	78	1	50	7	70	20	69
4months	1	12	0	0	1	50	3	30	5	17
5months	1	12	0	0	0	0	0	0	1	3
6months	1	12	0	0	0	0	0	0	1	3
Total	8	100	9	100	2	100	10	100	29	100
Attended any refresher course										
Yes	7	70	8	80	10	100	2	20	27	68
No	3	30	2	20	0	0	8	80	13	32
Total	10	100	10	100	10	100	10	100	40	100
Attended refresher in PSE	7	70	8	80	10	100	2	20	27	68
Attended refresher growth monitoring	7	70	8	80	9	90	2	20	26	65
Attended training in community growth chart	5	50	6	60	9	90	2	20	22	55
Joint training with health workers	7	70	6	60	9	90	4	40	26	65
No satisfied with training	7	70	7	70	0	0	0	0	14	35
Total	10	100	10	100	10	100	10	100	40	100

Source: Planning commission of India , New Delhi*

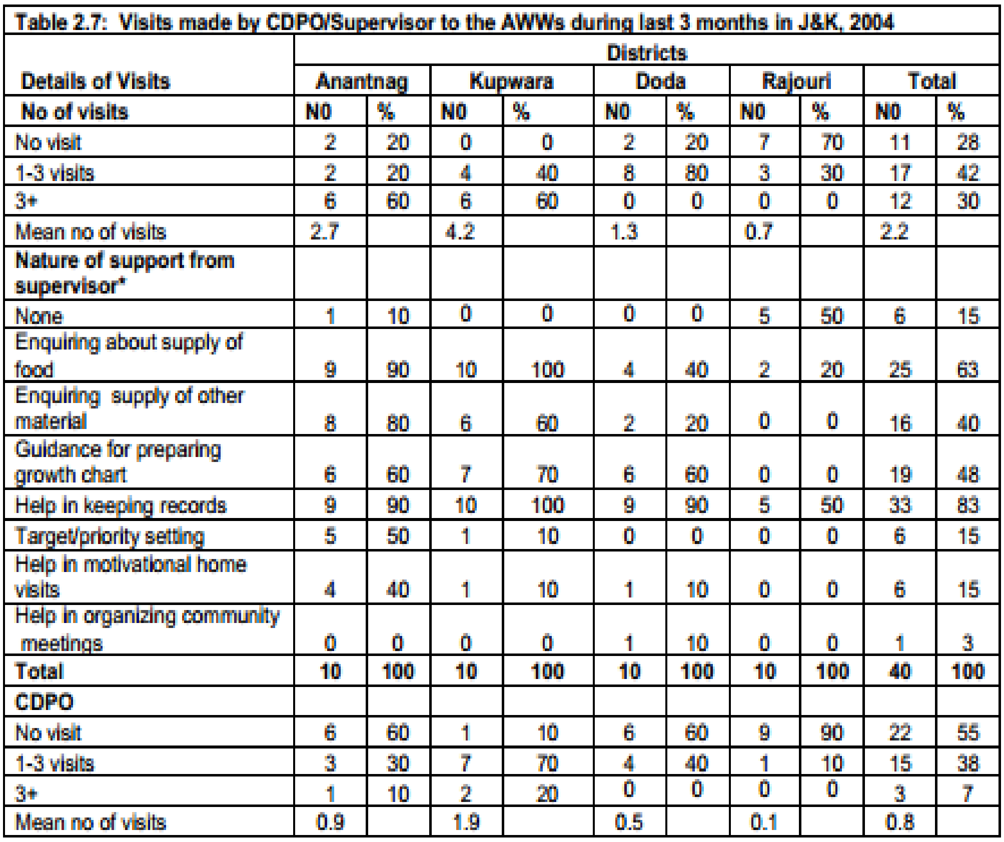


Table 2.7: Visits made by CDPO/Supervisor to the AWWs during last 3 months in J&K, 2004

Details of Visits	Districts									
	Anantnag		Kupwara		Doda		Rajouri		Total	
No of visits	**N0**	**%**	**N0**	**%**	**N0**	**%**	**N0**	**%**	**N0**	**%**
No visit	2	20	0	0	2	20	7	70	11	28
1-3 visits	2	20	4	40	8	80	3	30	17	42
3+	6	60	6	60	0	0	0	0	12	30
Mean no of visits	2.7		4.2		1.3		0.7		2.2	
Nature of support from supervisor*										
None	1	10	0	0	0	0	5	50	6	15
Enquiring about supply of food	9	90	10	100	4	40	2	20	25	63
Enquiring supply of other material	8	80	6	60	2	20	0	0	16	40
Guidance for preparing growth chart	6	60	7	70	6	60	0	0	19	48
Help in keeping records	9	90	10	100	9	90	5	50	33	83
Target/priority setting	5	50	1	10	0	0	0	0	6	15
Help in motivational home visits	4	40	1	10	1	10	0	0	6	15
Help in organizing community meetings	0	0	0	0	1	10	0	0	1	3
Total	**10**	**100**	**10**	**100**	**10**	**100**	**10**	**100**	**40**	**100**
CDPO										
No visit	6	60	1	10	6	60	9	90	22	55
1-3 visits	3	30	7	70	4	40	1	10	15	38
3+	1	10	2	20	0	0	0	0	3	7
Mean no of visits	0.9		1.9		0.5		0.1		0.8	

*.Multiple response

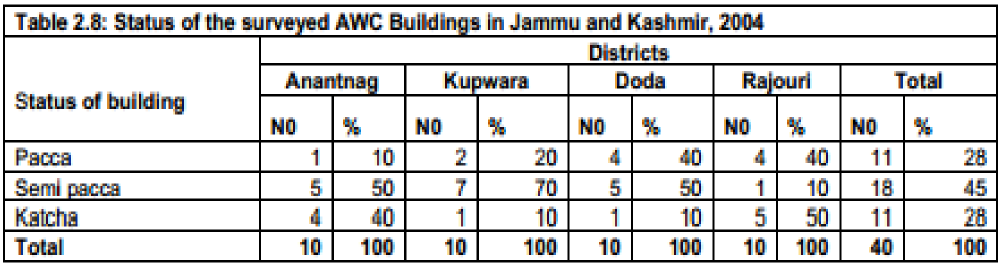


Table 2.8: Status of the surveyed AWC Buildings in Jammu and Kashmir, 2004

Status of building	Districts									
	Anantnag		Kupwara		Doda		Rajouri		Total	
	N0	**%**	**N0**	**%**	**N0**	**%**	**N0**	**%**	**N0**	**%**
Pacca	1	10	2	20	4	40	4	40	11	28
Semi pacca	5	50	7	70	5	50	1	10	18	45
Katcha	4	40	1	10	1	10	5	50	11	28
Total	**10**	**100**	**10**	**100**	**10**	**100**	**10**	**100**	**40**	**100**

Source: Planning Commission of India, New Delhi*

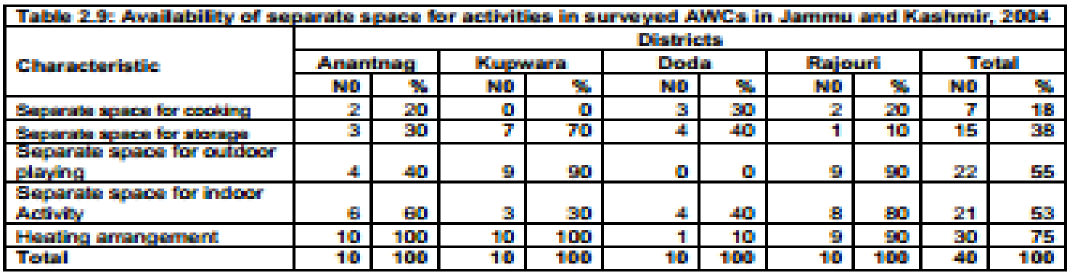


Table 2.9: Availability of separate space for activities in surveyed AWCs in Jammu and Kashmir, 2004

Characteristic	Districts									
	Anantnag		Kupwara		Doda		Rajouri		Total	
	N0	%	N0	%	N0	%	N0	%	N0	%
Separate space for cooking	2	20	0	0	3	30	2	20	7	18
Separate space for storage	3	30	7	70	4	40	1	10	15	38
Separate space for outdoor playing	4	40	9	90	0	0	9	90	22	55
Separate space for indoor Activity	6	60	3	30	4	40	8	80	21	53
Heating arrangement	10	100	10	100	1	10	9	90	30	75
Total	10	100	10	100	10	100	10	100	40	100

* Multiple responses

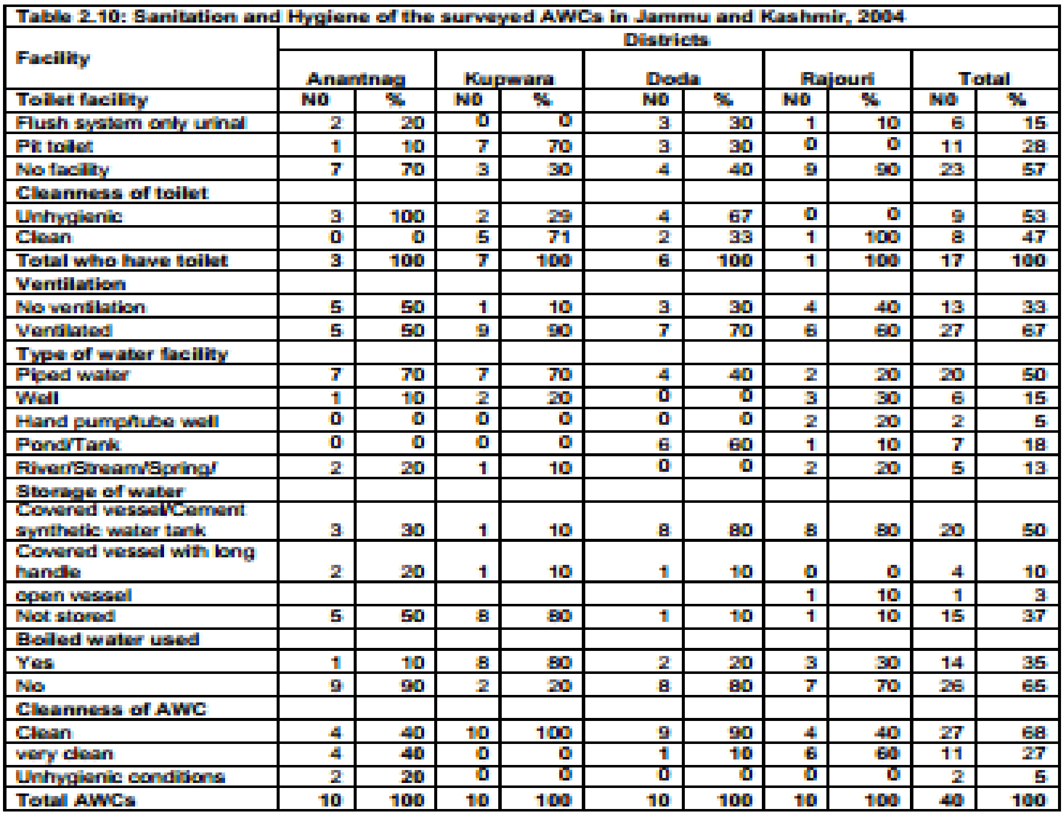


Table 2.10: Sanitation and Hygiene of the surveyed AWCs in Jammu and Kashmir, 2004

Facility	Districts									
	Anantnag		Kupwara		Doda		Rajouri		Total	
Toilet facility	N0	%	N0	%	N0	%	N0	%	N0	%
Flush system only urinal	2	20	0	0	3	30	1	10	6	15
Pit toilet	1	10	7	70	3	30	0	0	11	28
No facility	7	70	3	30	4	40	9	90	23	57
Cleanness of toilet										
Unhygienic	3	100	2	29	4	67	0	0	9	53
Clean	0	0	5	71	2	33	1	100	8	47
Total who have toilet	3	100	7	100	6	100	1	100	17	100
Ventilation										
No ventilation	5	50	1	10	3	30	4	40	13	33
Ventilated	5	50	9	90	7	70	6	60	27	67
Type of water facility										
Piped water	7	70	7	70	4	40	2	20	20	50
Well	1	10	2	20	0	0	3	30	6	15
Hand pump/tube well	0	0	0	0	0	0	2	20	2	5
Pond/Tank	0	0	0	0	6	60	1	10	7	18
River/Stream/Spring/	2	20	1	10	0	0	2	20	5	13
Storage of water										
Covered vessel/Cement synthetic water tank	3	30	1	10	8	80	8	80	20	50
Covered vessel with long handle	2	20	1	10	1	10	0	0	4	10
open vessel							1	10	1	3
Not stored	5	50	8	80	1	10	1	10	15	37
Boiled water used										
Yes	1	10	8	80	2	20	3	30	14	35
No	9	90	2	20	8	80	7	70	26	65
Cleanness of AWC										
Clean	4	40	10	100	9	90	4	40	27	68
very clean	4	40	0	0	1	10	6	60	11	27
Unhygienic conditions	2	20	0	0	0	0	0	0	2	5
Total AWCs	10	100	10	100	10	100	10	100	40	100

Source: Planning commission of India, New Delhi*

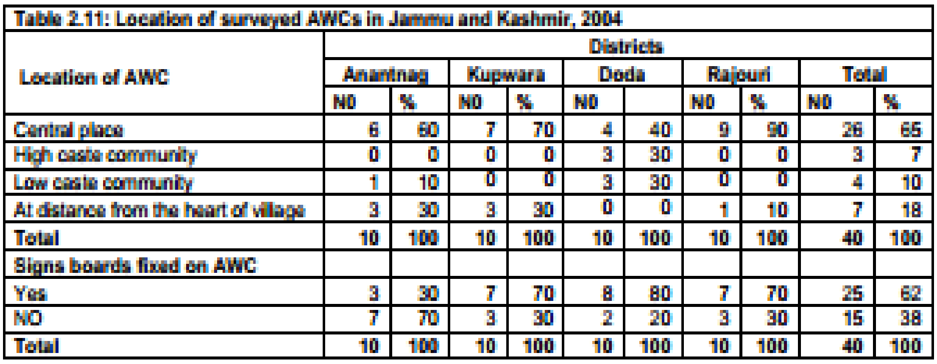


Table 2.11: Location of surveyed AWCs in Jammu and Kashmir, 2004

Location of AWC	Districts									
	Anantnag		Kupwara		Doda		Rajouri		Total	
	N0	%	N0	%	N0		N0	%	N0	%
Central place	6	60	7	70	4	40	9	90	26	65
High caste community	0	0	0	0	3	30	0	0	3	7
Low caste community	1	10	0	0	3	30	0	0	4	10
At distance from the heart of village	3	30	3	30	0	0	1	10	7	18
Total	10	100	10	100	10	100	10	100	40	100
Signs boards fixed on AWC										
Yes	3	30	7	70	8	80	7	70	25	62
NO	7	70	3	30	2	20	3	30	15	38
Total	10	100	10	100	10	100	10	100	40	100

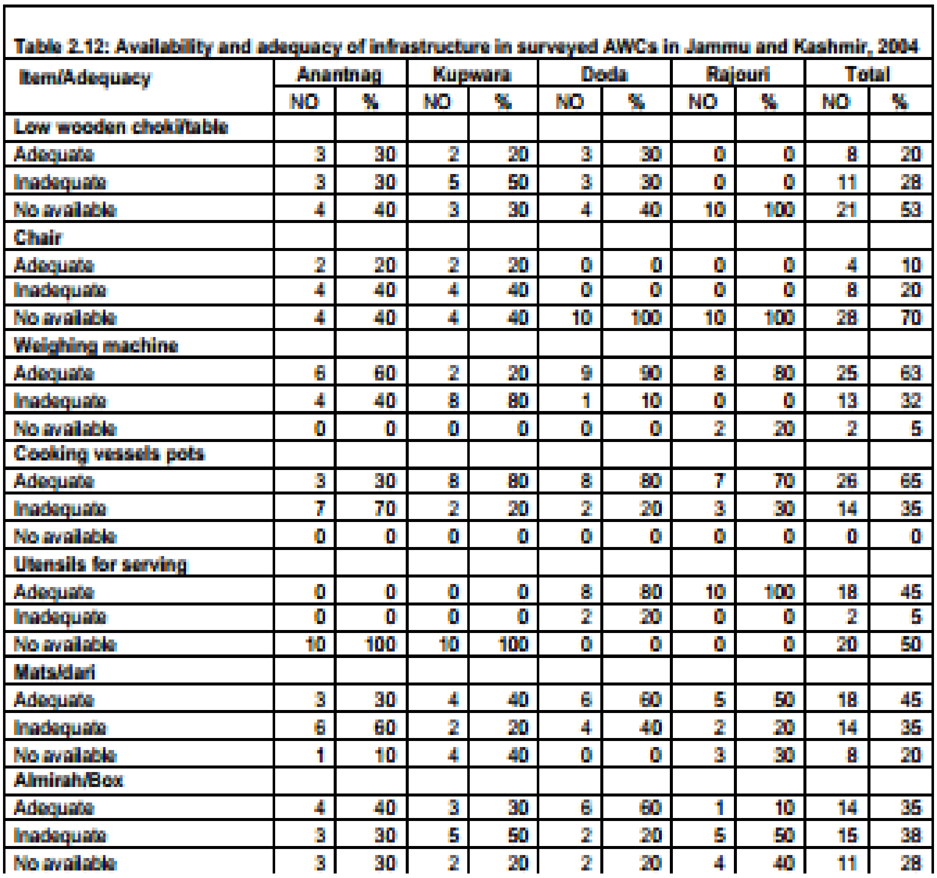
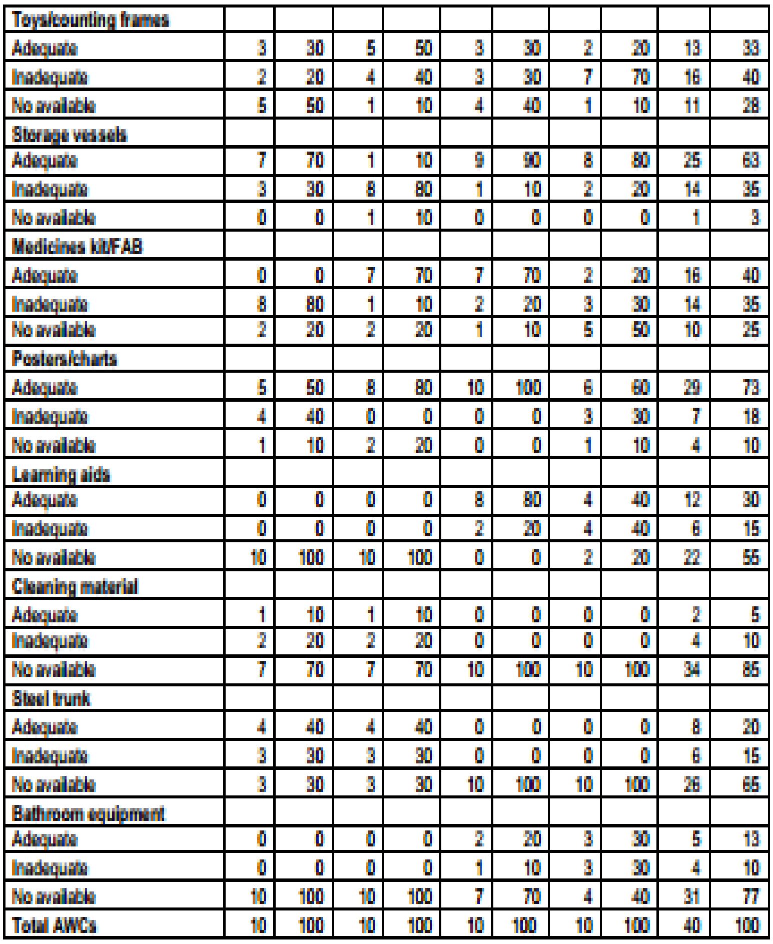


Table 2.12: Availability and adequacy of infrastructure in surveyed AWCs in Jammu and Kashmir, 2004

Item/Adequacy	Anantnag		Kupwara		Doda		Rajouri		Total	
	NO	%	NO	%	NO	%	NO	%	NO	%
Low wooden choki/table										
Adequate	3	30	2	20	3	30	0	0	8	20
Inadequate	3	30	5	50	3	30	0	0	11	28
No available	4	40	3	30	4	40	10	100	21	53
Chair										
Adequate	2	20	2	20	0	0	0	0	4	10
Inadequate	4	40	4	40	0	0	0	0	8	20
No available	4	40	4	40	10	100	10	100	28	70
Weighing machine										
Adequate	6	60	2	20	9	90	8	80	25	63
Inadequate	4	40	8	80	1	10	0	0	13	32
No available	0	0	0	0	0	0	2	20	2	5
Cooking vessels pots										
Adequate	3	30	8	80	8	80	7	70	26	65
Inadequate	7	70	2	20	2	20	3	30	14	35
No available	0	0	0	0	0	0	0	0	0	0
Utensils for serving										
Adequate	0	0	0	0	8	80	10	100	18	45
Inadequate	0	0	0	0	2	20	0	0	2	5
No available	10	100	10	100	0	0	0	0	20	50
Mats/dari										
Adequate	3	30	4	40	6	60	5	50	18	45
Inadequate	6	60	2	20	4	40	2	20	14	35
No available	1	10	4	40	0	0	3	30	8	20
Almirah/Box										
Adequate	4	40	3	30	6	60	1	10	14	35
Inadequate	3	30	5	50	2	20	5	50	15	38
No available	3	30	2	20	2	20	4	40	11	28

Source: Planning Commission of India, New Delhi*



Toys/counting frames										
Adequate	3	30	5	50	3	30	2	20	13	33
Inadequate	2	20	4	40	3	30	7	70	16	40
No available	5	50	1	10	4	40	1	10	11	28
Storage vessels										
Adequate	7	70	1	10	9	90	8	80	25	63
Inadequate	3	30	8	80	1	10	2	20	14	35
No available	0	0	1	10	0	0	0	0	1	3
Medicines kit/FAB										
Adequate	0	0	7	70	7	70	2	20	16	40
Inadequate	8	80	1	10	2	20	3	30	14	35
No available	2	20	2	20	1	10	5	50	10	25
Posters/charts										
Adequate	5	50	8	80	10	100	6	60	29	73
Inadequate	4	40	0	0	0	0	3	30	7	18
No available	1	10	2	20	0	0	1	10	4	10
Learning aids										
Adequate	0	0	0	0	8	80	4	40	12	30
Inadequate	0	0	0	0	2	20	4	40	6	15
No available	10	100	10	100	0	0	2	20	22	55
Cleaning material										
Adequate	1	10	1	10	0	0	0	0	2	5
Inadequate	2	20	2	20	0	0	0	0	4	10
No available	7	70	7	70	10	100	10	100	34	85
Steel trunk										
Adequate	4	40	4	40	0	0	0	0	8	20
Inadequate	3	30	3	30	0	0	0	0	6	15
No available	3	30	3	30	10	100	10	100	26	65
Bathroom equipment										
Adequate	0	0	0	0	2	20	3	30	5	13
Inadequate	0	0	0	0	1	10	3	30	4	10
No available	10	100	10	100	7	70	4	40	31	77
Total AWCs	10	100	10	100	10	100	10	100	40	100

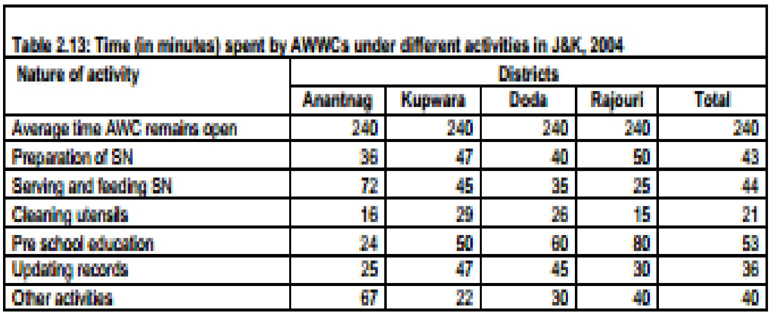


Table 2.13: Time (in minutes) spent by AWWCs under different activities in J&K, 2004

Nature of activity	Districts				
	Anantnag	Kupwara	Doda	Rajouri	Total
Average time AWC remains open	240	240	240	240	240
Preparation of SN	36	47	40	50	43
Serving and feeding SN	72	45	35	25	44
Cleaning utensils	16	29	26	15	21
Pre school education	24	50	60	80	53
Updating records	25	47	45	30	36
Other activities	67	22	30	40	40

Source: Planning Commission of India, New Delhi *

Table 2.14: Criterion used for the selection of the beneficiary children in Jammu and Kashmir, 2004										
Characteristics	Districts									
	Anantnag		Kupwara		Doda		Rajouri		Total	
Age of the child at enrolment	N0	%	N0	%	N0		N0	%	N0	%
1-12 months	45	90	0	0	0	0	35	70	80	40
13-36 months	5	10	20	40	25	50	15	30	65	32
37-72 months	0	0	30	60	25	50	0	0	55	28
Economic status										
Rich	14	28	10	20	3	6	7	14	34	17
Poor	21	42	40	80	47	94	43	86	151	75
Very poor	15	30	0	0	0	0	0	0	15	8
Caste of the household										
SC/ST	0	0	0	0	11	22	21	42	32	16
OBC	11	22	7	14	0	0	0	0	18	9
Others	39	78	43	86	39	78	29	58	150	75
Distance from AWC										

Table 2.9: Availability of separate space for activities in surveyed AWCs in Jammu and Kashmir, 2004										
Characteristic	Districts									
	Anantnag		Kupwara		Doda		Rajouri		Total	
	N0	%	N0	%	N0	%	N0	%	N0	%
Separate space for cooking	2	20	0	0	3	30	2	20	7	18
Separate space for storage	3	30	7	70	4	40	1	10	15	38
Separate space for outdoor playing	4	40	9	90	0	0	9	90	22	55
Separate space for indoor Activity	6	60	3	30	4	40	8	80	21	53
Heating arrangement	10	100	10	100	1	10	9	90	30	75
Total	10	100	10	100	10	100	10	100	40	100

* Multiple responses

Table 2.10: Sanitation and Hygiene of the surveyed AWCs in Jammu and Kashmir, 2004										
Facility	Districts									
	Anantnag		Kupwara		Doda		Rajouri		Total	
Toilet facility	N0	%	N0	%	N0	%	N0	%	N0	%
Flush system only urinal	2	20	0	0	3	30	1	10	6	15
Pit toilet	1	10	7	70	3	30	0	0	11	28
No facility	7	70	3	30	4	40	9	90	23	57
Cleanness of toilet										
Unhygienic	3	100	2	29	4	67	0	0	9	53
Clean	0	0	5	71	2	33	1	100	8	47
Total who have toilet	3	100	7	100	6	100	1	100	17	100
Ventilation										
No ventilation	5	50	1	10	3	30	4	40	13	33
Ventilated	5	50	9	90	7	70	6	60	27	67
Type of water facility										
Piped water	7	70	7	70	4	40	2	20	20	50
Well	1	10	2	20	0	0	3	30	6	15
Hand pump/tube well	0	0	0	0	0	0	2	20	2	5
Pond/Tank	0	0	0	0	6	60	1	10	7	18
River/Stream/Spring/	2	20	1	10	0	0	2	20	5	13
Storage of water										
Covered vessel/Cement synthetic water tank	3	30	1	10	8	80	8	80	20	50
Covered vessel with long handle	2	20	1	10	1	10	0	0	4	10
open vessel							1	10	1	3
Not stored	5	50	8	80	1	10	1	10	15	37
Boiled water used										
Yes	1	10	8	80	2	20	3	30	14	35
No	9	90	2	20	8	80	7	70	26	65
Cleanness of AWC										
Clean	4	40	10	100	9	90	4	40	27	68
very clean	4	40	0	0	1	10	6	60	11	27
Unhygienic conditions	2	20	0	0	0	0	0	0	2	5
Total AWCs	10	100	10	100	10	100	10	100	40	100

Source: Planning Commission of India, New Delhi*

Source: Planning commission of India , New Delhi*

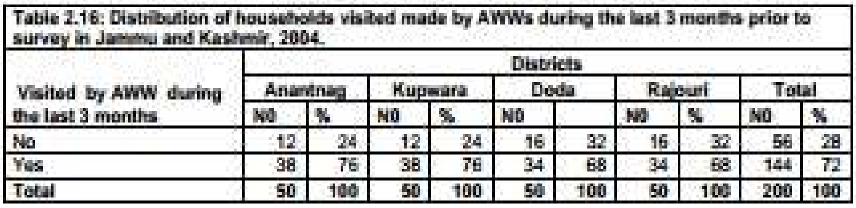


Table 2.16: Distribution of households visited made by AWWs during the last 3 months prior to survey in Jammu and Kashmir, 2004.

Visited by AWW during the last 3 months	Districts									
	Anantnag		Kupwara		Doda		Rajouri		Total	
	N0	%	N0	%	N0		N0	%	N0	%
No	12	24	12	24	16	32	16	32	56	28
Yes	38	76	38	76	34	68	34	68	144	72
Total	50	100	50	100	50	100	50	100	200	100

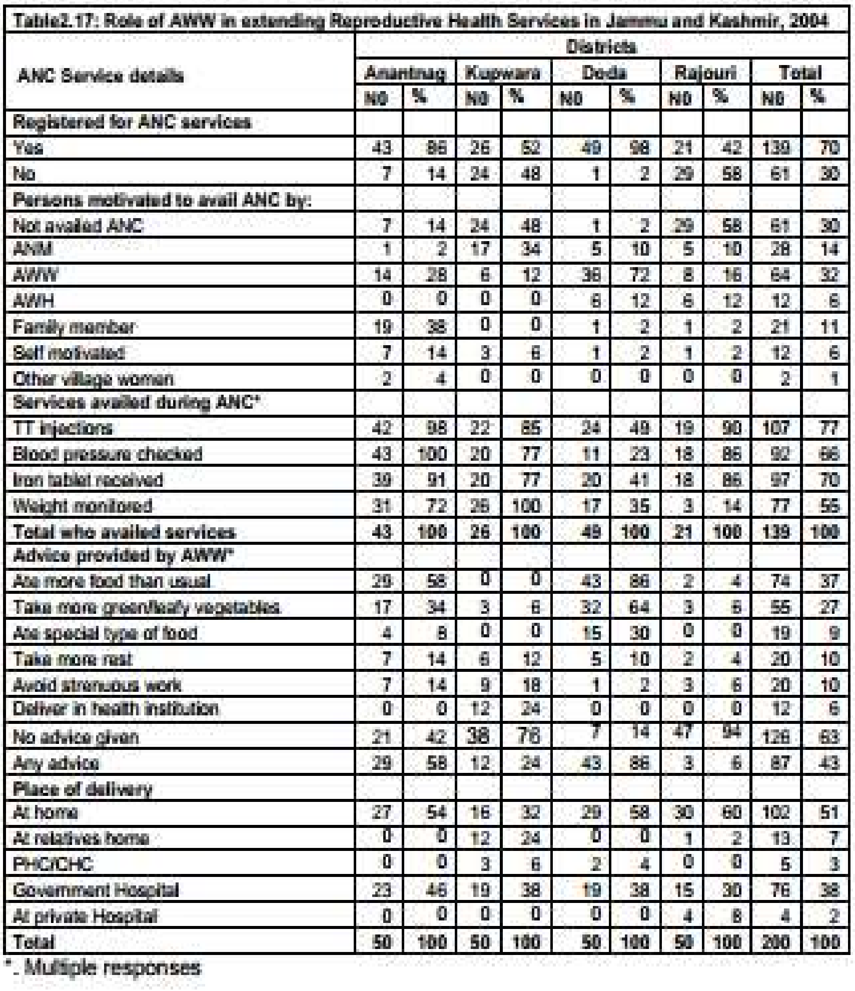


Table2.17: Role of AWW in extending Reproductive Health Services in Jammu and Kashmir, 2004

ANC Service details	Districts									
	Anantnag		Kupwara		Doda		Rajouri		Total	
	N0	%	N0	%	N0	%	N0	%	N0	%
Registered for ANC services										
Yes	43	86	26	52	49	98	21	42	139	70
No	7	14	24	48	1	2	29	58	61	30
Persons motivated to avail ANC by:										
Not availed ANC	7	14	24	48	1	2	29	58	61	30
ANM	1	2	17	34	5	10	5	10	28	14
AWW	14	28	6	12	36	72	8	16	64	32
AWH	0	0	0	0	6	12	6	12	12	6
Family member	19	38	0	0	1	2	1	2	21	11
Self motivated	7	14	3	6	1	2	1	2	12	6
Other village women	2	4	0	0	0	0	0	0	2	1
Services availed during ANC*										
TT injections	42	98	22	85	24	49	19	90	107	77
Blood pressure checked	43	100	20	77	11	23	18	86	92	66
Iron tablet received	39	91	20	77	20	41	18	86	97	70
Weight monitored	31	72	26	100	17	35	3	14	77	55
Total who availed services	43	100	26	100	49	100	21	100	139	100
Advice provided by AWW*										
Ate more food than usual	29	58	0	0	43	86	2	4	74	37
Take more green/leafy vegetables	17	34	3	6	32	64	3	6	55	27
Ate special type of food	4	8	0	0	15	30	0	0	19	9
Take more rest	7	14	6	12	5	10	2	4	20	10
Avoid strenuous work	7	14	9	18	1	2	3	6	20	10
Deliver in health institution	0	0	12	24	0	0	0	0	12	6
No advice given	21	42	38	76	7	14	47	94	126	63
Any advice	29	58	12	24	43	86	3	6	87	43
Place of delivery										
At home	27	54	16	32	29	58	30	60	102	51
At relatives home	0	0	12	24	0	0	1	2	13	7
PHC/CHC	0	0	3	6	2	4	0	0	5	3
Government Hospital	23	46	19	38	19	38	15	30	76	38
At private Hospital	0	0	0	0	0	0	4	8	4	2
Total	50	100	50	100	50	100	50	100	200	100

*. Multiple responses

Source: Planning Commission of India , New Delhi *

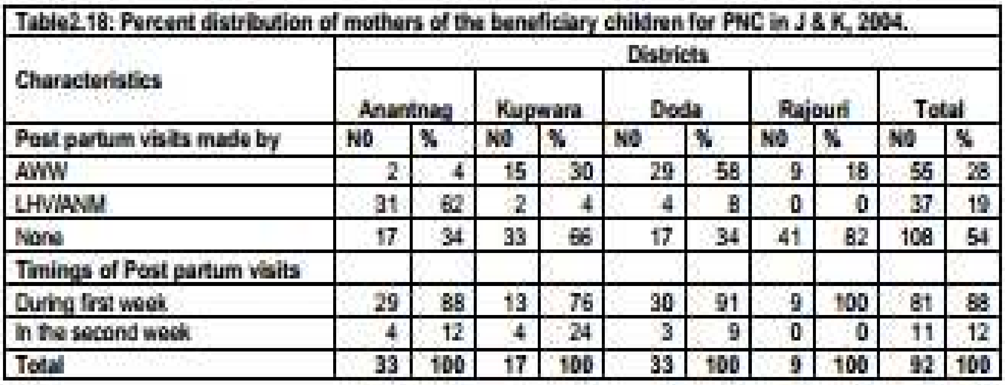


Table2.18: Percent distribution of mothers of the beneficiary children for PNC in J & K, 2004.

Characteristics	Districts									
	Anantnag		Kupwara		Doda		Rajouri		Total	
Post partum visits made by	N0	%	N0	%	N0	%	N0	%	N0	%
AWW	2	4	15	30	29	58	9	18	55	28
LHV/ANM	31	62	2	4	4	8	0	0	37	19
None	17	34	33	66	17	34	41	82	108	54
Timings of Post partum visits										
During first week	29	88	13	76	30	91	9	100	81	88
In the second week	4	12	4	24	3	9	0	0	11	12
Total	33	100	17	100	33	100	9	100	92	100

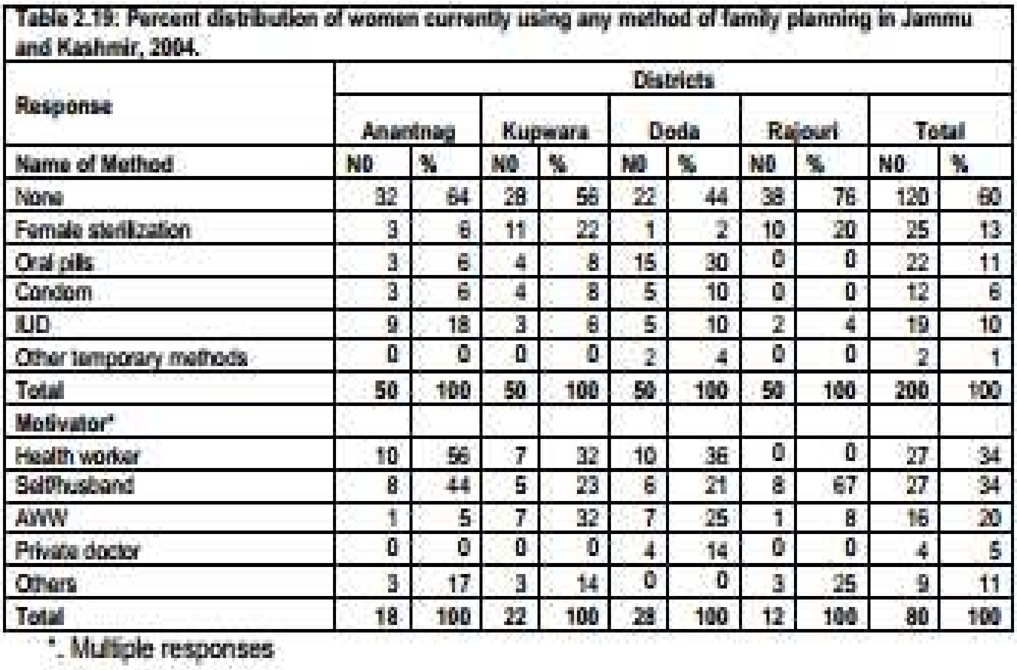


Table 2.19: Percent distribution of women currently using any method of family planning in Jammu and Kashmir, 2004.

Response	Districts									
	Anantnag		Kupwara		Doda		Rajouri		Total	
Name of Method	N0	%	N0	%	N0	%	N0	%	N0	%
None	32	64	28	56	22	44	38	76	120	60
Female sterilization	3	6	11	22	1	2	10	20	25	13
Oral pills	3	6	4	8	15	30	0	0	22	11
Condom	3	6	4	8	5	10	0	0	12	6
IUD	9	18	3	6	5	10	2	4	19	10
Other temporary methods	0	0	0	0	2	4	0	0	2	1
Total	50	100	50	100	50	100	50	100	200	100
Motivator*										
Health worker	10	56	7	32	10	36	0	0	27	34
Self/husband	8	44	5	23	6	21	8	67	27	34
AWW	1	5	7	32	7	25	1	8	16	20
Private doctor	0	0	0	0	4	14	0	0	4	5
Others	3	17	3	14	0	0	3	25	9	11
Total	18	100	22	100	28	100	12	100	80	100

*. Multiple responses

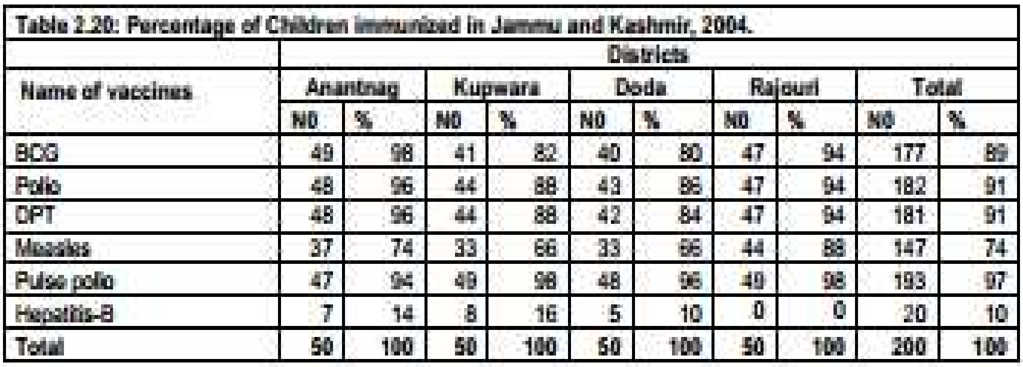


Table 2.20: Percentage of Children immunized in Jammu and Kashmir, 2004.

Name of vaccines	Districts									
	Anantnag		Kupwara		Doda		Rajouri		Total	
	N0	%	N0	%	N0	%	N0	%	N0	%
BCG	49	98	41	82	40	80	47	94	177	89
Polio	48	96	44	88	43	86	47	94	182	91
DPT	48	96	44	88	42	84	47	94	181	91
Measles	37	74	33	66	33	66	44	88	147	74
Pulse polio	47	94	49	98	48	96	49	98	193	97
Hepatitis-B	7	14	8	16	5	10	0	0	20	10
Total	50	100	50	100	50	100	50	100	200	100

Source: Planning commission of India, New Delhi*

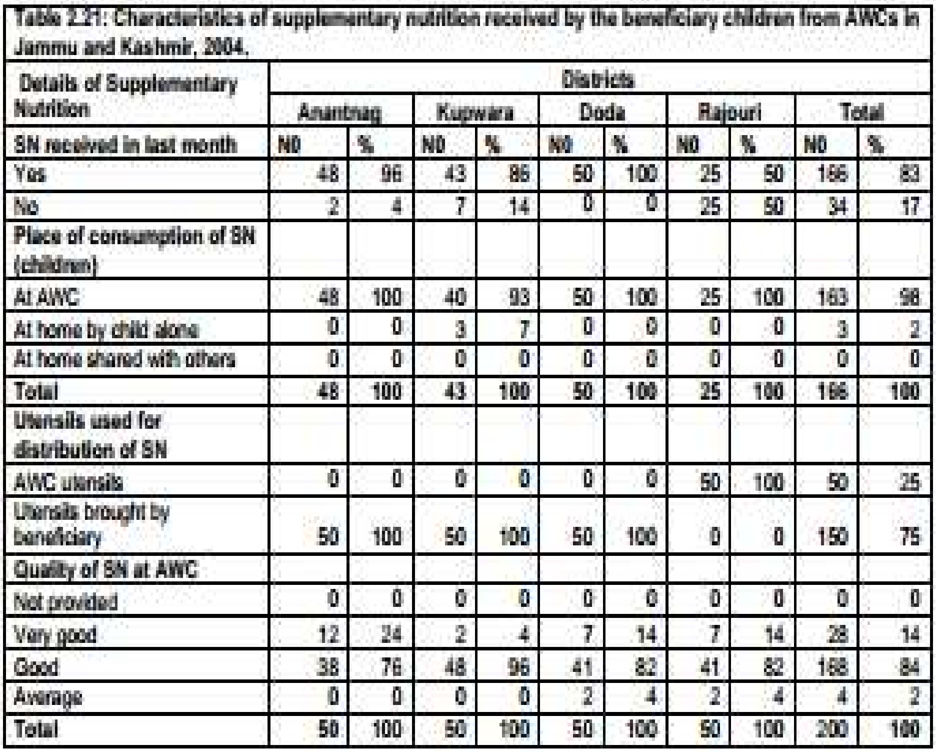


Table 2.21: Characteristics of supplementary nutrition received by the beneficiary children from AWCs in Jammu and Kashmir, 2004.

Details of Supplementary Nutrition	Districts									
	Anantnag		Kupwara		Doda		Rajouri		Total	
SN received in last month	N0	%	N0	%	N0	%	N0	%	N0	%
Yes	48	96	43	86	50	100	25	50	166	83
No	2	4	7	14	0	0	25	50	34	17
Place of consumption of SN (children)										
At AWC	48	100	40	93	50	100	25	100	163	98
At home by child alone	0	0	3	7	0	0	0	0	3	2
At home shared with others	0	0	0	0	0	0	0	0	0	0
Total	48	100	43	100	50	100	25	100	166	100
Utensils used for distribution of SN										
AWC utensils	0	0	0	0	0	0	50	100	50	25
Utensils brought by beneficiary	50	100	50	100	50	100	0	0	150	75
Quality of SN at AWC										
Not provided	0	0	0	0	0	0	0	0	0	0
Very good	12	24	2	4	7	14	7	14	28	14
Good	38	76	48	96	41	82	41	82	168	84
Average	0	0	0	0	2	4	2	4	4	2
Total	50	100	50	100	50	100	50	100	200	100

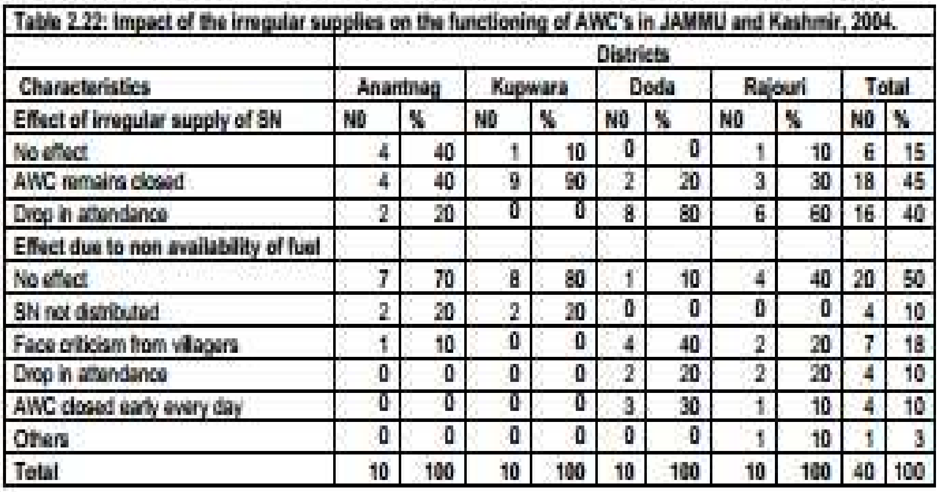


Table 2.22: Impact of the irregular supplies on the functioning of AWC's in JAMMU and Kashmir, 2004.

	Districts									
Characteristics	Anantnag		Kupwara		Doda		Rajouri		Total	
Effect of irregular supply of SN	N0	%	N0	%	N0	%	N0	%	N0	%
No effect	4	40	1	10	0	0	1	10	6	15
AWC remains closed	4	40	9	90	2	20	3	30	18	45
Drop in attendance	2	20	0	0	8	80	6	60	16	40
Effect due to non availability of fuel										
No effect	7	70	8	80	1	10	4	40	20	50
SN not distributed	2	20	2	20	0	0	0	0	4	10
Face criticism from villagers	1	10	0	0	4	40	2	20	7	18
Drop in attendance	0	0	0	0	2	20	2	20	4	10
AWC closed early every day	0	0	0	0	3	30	1	10	4	10
Others	0	0	0	0	0	0	1	10	1	3
Total	10	100	10	100	10	100	10	100	40	100

Source: Planning commission of India, New Delhi*

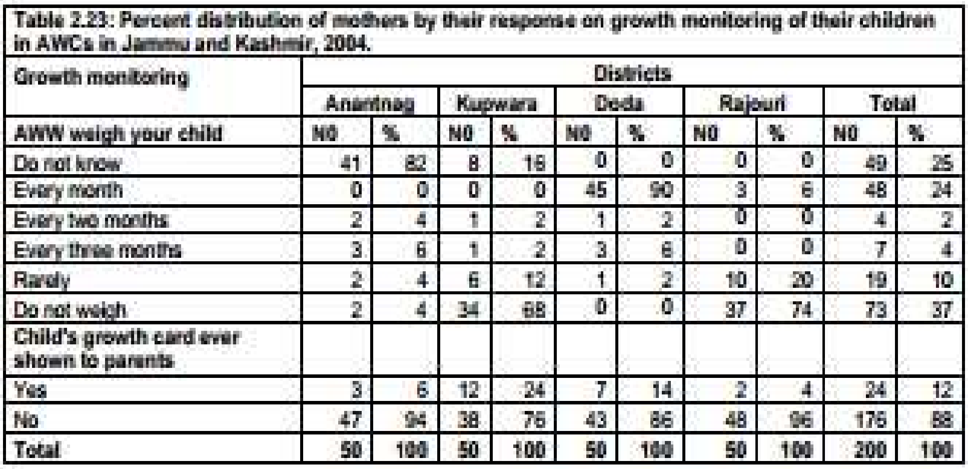


Table 2.23: Percent distribution of mothers by their response on growth monitoring of their children in AWCs in Jammu and Kashmir, 2004.

Growth monitoring	Districts									
	Anantnag		Kupwara		Doda		Rajouri		Total	
AWW weigh your child	N0	%	N0	%	N0	%	N0	%	N0	%
Do not know	41	82	8	16	0	0	0	0	49	25
Every month	0	0	0	0	45	90	3	6	48	24
Every two months	2	4	1	2	1	2	0	0	4	2
Every three months	3	6	1	2	3	6	0	0	7	4
Rarely	2	4	6	12	1	2	10	20	19	10
Do not weigh	2	4	34	68	0	0	37	74	73	37
Child's growth card ever shown to parents										
Yes	3	6	12	24	7	14	2	4	24	12
No	47	94	38	76	43	86	48	96	176	88
Total	50	100	50	100	50	100	50	100	200	100

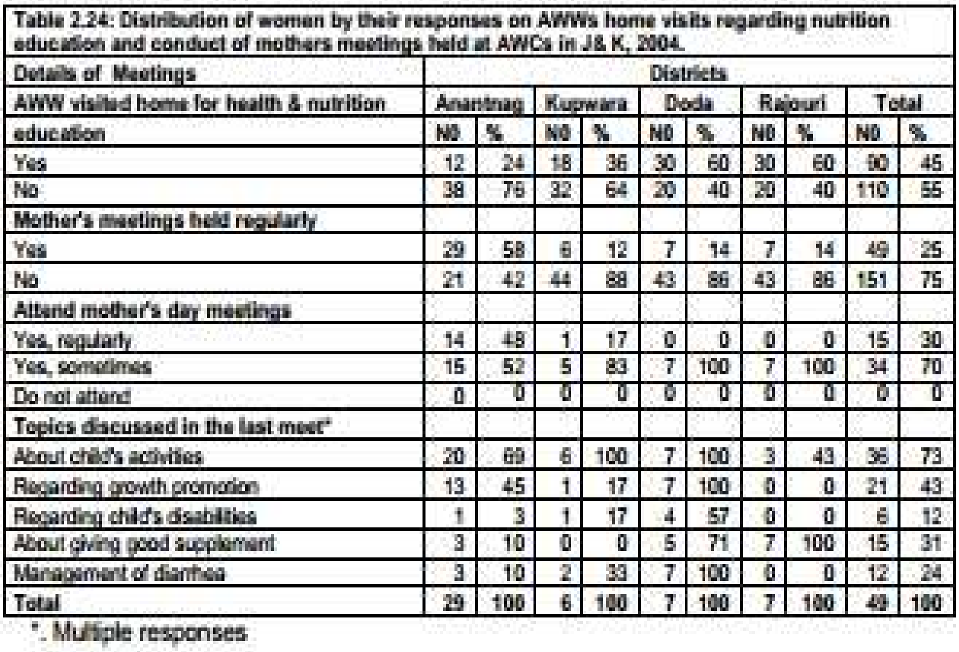


Table 2.24: Distribution of women by their responses on AWWs home visits regarding nutrition education and conduct of mothers meetings held at AWCs in J& K, 2004.

Details of Meetings	Districts									
AWW visited home for health & nutrition	Anantnag		Kupwara		Doda		Rajouri		Total	
education	N0	%	N0	%	N0	%	N0	%	N0	%
Yes	12	24	18	36	30	60	30	60	90	45
No	38	76	32	64	20	40	20	40	110	55
Mother's meetings held regularly										
Yes	29	58	6	12	7	14	7	14	49	25
No	21	42	44	88	43	86	43	86	151	75
Attend mother's day meetings										
Yes, regularly	14	48	1	17	0	0	0	0	15	30
Yes, sometimes	15	52	5	83	7	100	7	100	34	70
Do not attend	0	0	0	0	0	0	0	0	0	0
Topics discussed in the last meet*										
About child's activities	20	69	6	100	7	100	3	43	36	73
Regarding growth promotion	13	45	1	17	7	100	0	0	21	43
Regarding child's disabilities	1	3	1	17	4	57	0	0	6	12
About giving good supplement	3	10	0	0	5	71	7	100	15	31
Management of diarrhea	3	10	2	33	7	100	0	0	12	24
Total	29	100	6	100	7	100	7	100	49	100

*. Multiple responses

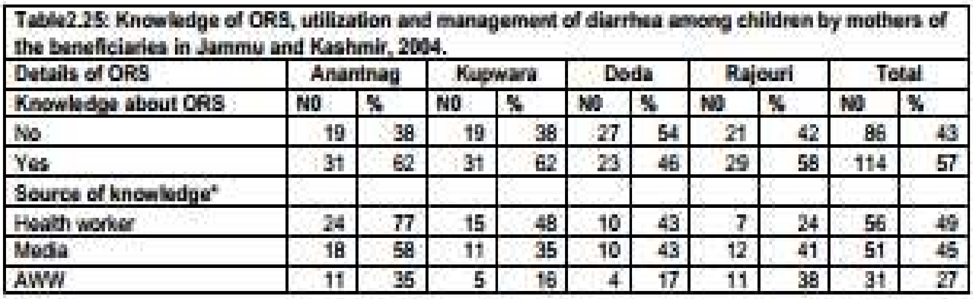
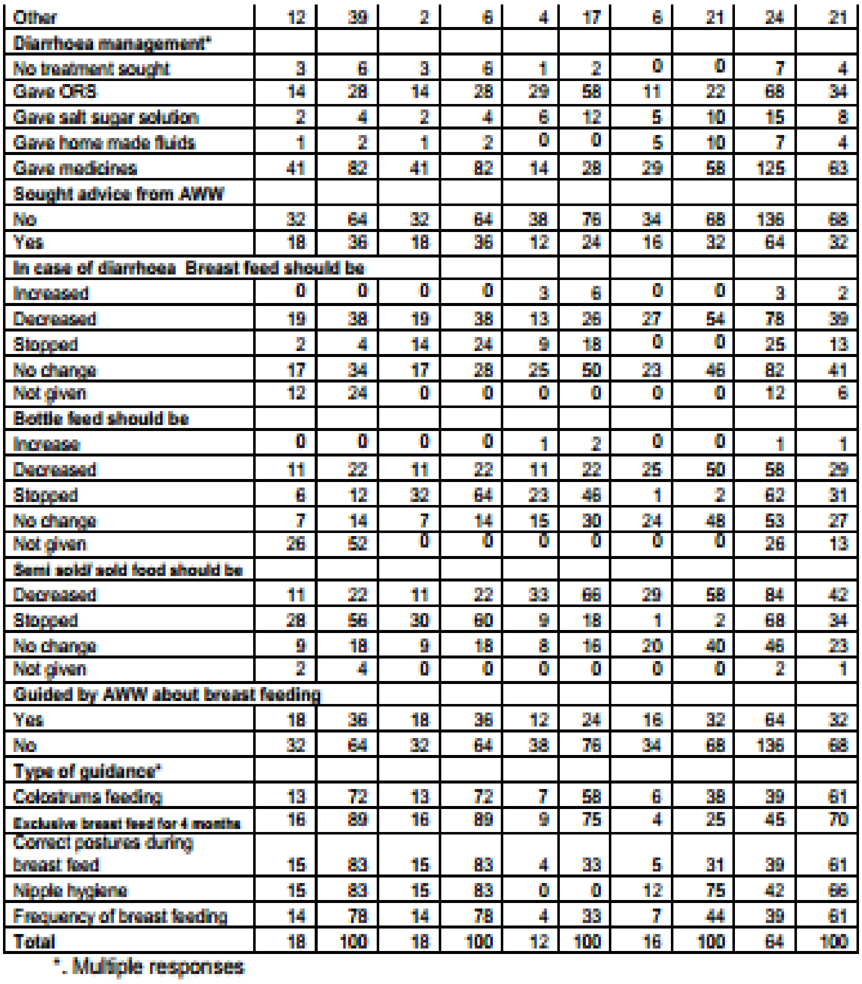


Table2.25: Knowledge of ORS, utilization and management of diarrhea among children by mothers of the beneficiaries in Jammu and Kashmir, 2004.

Details of ORS	Ananinag		Kupwara		Doda		Rajouri		Total	
Knowledge about ORS	N0	%	N0	%	N0	%	N0	%	N0	%
No	19	38	19	38	27	54	21	42	86	43
Yes	31	62	31	62	23	46	29	58	114	57
Source of knowledge*										
Health worker	24	77	15	48	10	43	7	24	56	49
Media	18	58	11	35	10	43	12	41	51	45
AWW	11	35	5	16	4	17	11	38	31	27

Source: Planning Commission of India, New Delhi *



Other	12	39	2	6	4	17	6	21	24	21
Diarrhoea management*										
No treatment sought	3	6	3	6	1	2	0	0	7	4
Gave ORS	14	28	14	28	29	58	11	22	68	34
Gave salt sugar solution	2	4	2	4	6	12	5	10	15	8
Gave home made fluids	1	2	1	2	0	0	5	10	7	4
Gave medicines	41	82	41	82	14	28	29	58	125	63
Sought advice from AWW										
No	32	64	32	64	38	76	34	68	136	68
Yes	18	36	18	36	12	24	16	32	64	32
In case of diarrhoea Breast feed should be										
Increased	0	0	0	0	3	6	0	0	3	2
Decreased	19	38	19	38	13	26	27	54	78	39
Stopped	2	4	14	24	9	18	0	0	25	13
No change	17	34	17	28	25	50	23	46	82	41
Not given	12	24	0	0	0	0	0	0	12	6
Bottle feed should be										
Increase	0	0	0	0	1	2	0	0	1	1
Decreased	11	22	11	22	11	22	25	50	58	29
Stopped	6	12	32	64	23	46	1	2	62	31
No change	7	14	7	14	15	30	24	48	53	27
Not given	26	52	0	0	0	0	0	0	26	13
Semi sold/ sold food should be										
Decreased	11	22	11	22	33	66	29	58	84	42
Stopped	28	56	30	60	9	18	1	2	68	34
No change	9	18	9	18	8	16	20	40	46	23
Not given	2	4	0	0	0	0	0	0	2	1
Guided by AWW about breast feeding										
Yes	18	36	18	36	12	24	16	32	64	32
No	32	64	32	64	38	76	34	68	136	68
Type of guidance*										
Colostrums feeding	13	72	13	72	7	58	6	38	39	61
Exclusive breast feed for 4 months	16	89	16	89	9	75	4	25	45	70
Correct postures during breast feed	15	83	15	83	4	33	5	31	39	61
Nipple hygiene	15	83	15	83	0	0	12	75	42	66
Frequency of breast feeding	14	78	14	78	4	33	7	44	39	61
Total	18	100	18	100	12	100	16	100	64	100

*. Multiple responses

Source: Planning Commission New Delhi*

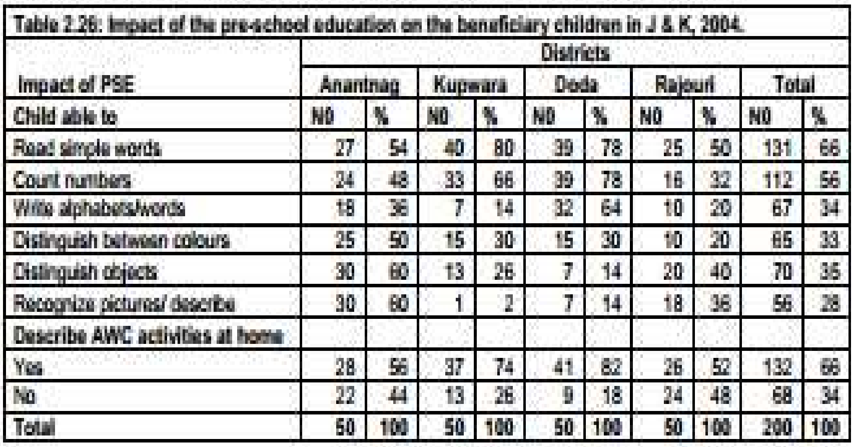


Table 2.26: Impact of the pre-school education on the beneficiary children in J & K, 2004.

Impact of PSE	Districts									
	Anantnag		Kupwara		Doda		Rajouri		Total	
Child able to	NO	%	NO	%	NO	%	NO	%	NO	%
Read simple words	27	54	40	80	39	78	25	50	131	66
Count numbers	24	48	33	66	39	78	16	32	112	56
Write alphabets/words	18	36	7	14	32	64	10	20	67	34
Distinguish between colours	25	50	15	30	15	30	10	20	65	33
Distinguish objects	30	60	13	26	7	14	20	40	70	35
Recognize pictures/ describe	30	60	1	2	7	14	18	36	56	28
Describe AWC activities at home										
Yes	28	56	37	74	41	82	26	52	132	66
No	22	44	13	26	9	18	24	48	68	34
Total	50	100	50	100	50	100	50	100	200	100

Source: Planning Commission New Delhi*

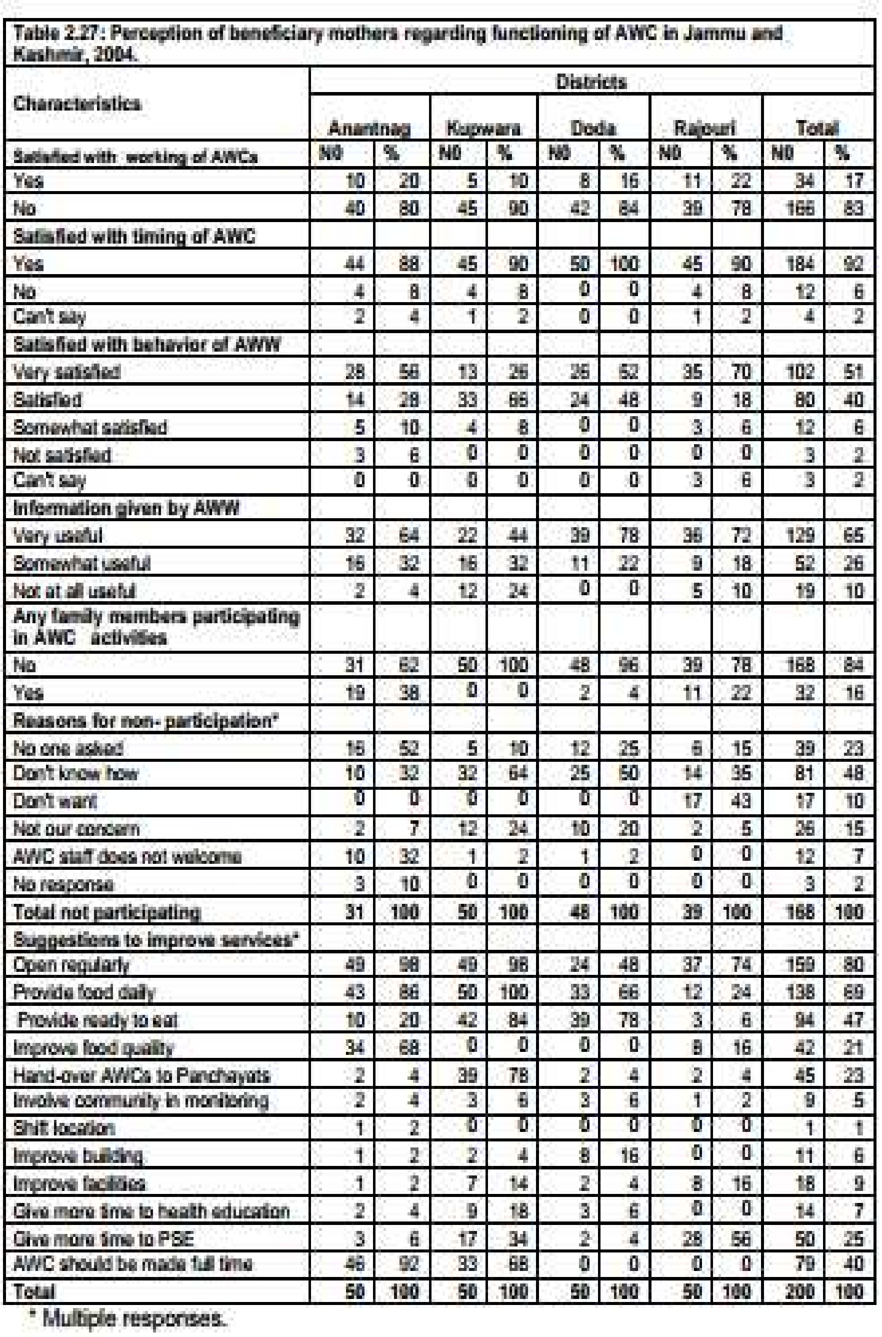


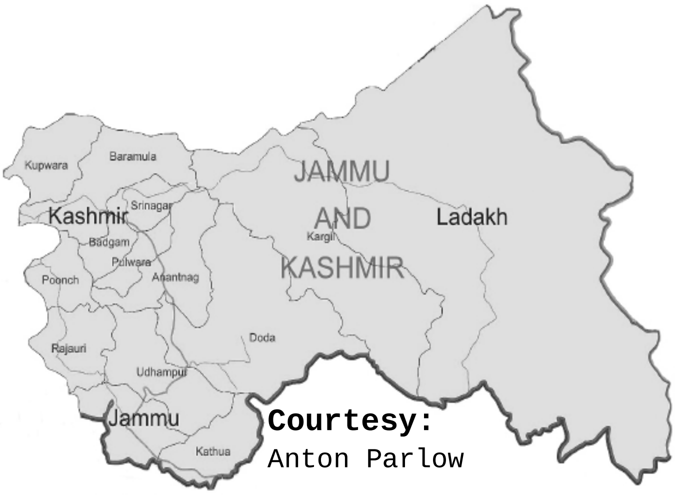
Table 2.27: Perception of beneficiary mothers regarding functioning of AWC in Jammu and Kashmir, 2004.

Characteristics	**Districts**									
	Anantnag		**Kupwara**		**Doda**		**Rajouri**		**Total**	
Satisfied with working of AWCs	**NO**	**%**	**NO**	**%**	**NO**	**%**	**NO**	**%**	**NO**	**%**
Yes	10	20	5	10	8	16	11	22	34	17
No	40	80	45	90	42	84	39	78	166	83
Satisfied with timing of AWC										
Yes	44	88	45	90	50	100	45	90	184	92
No	4	8	4	8	0	0	4	8	12	6
Can't say	2	4	1	2	0	0	1	2	4	2
Satisfied with behavior of AWW										
Very satisfied	28	56	13	26	26	52	35	70	102	51
Satisfied	14	28	33	66	24	48	9	18	80	40
Somewhat satisfied	5	10	4	8	0	0	3	6	12	6
Not satisfied	3	6	0	0	0	0	0	0	3	2
Can't say	0	0	0	0	0	0	3	6	3	2
Information given by AWW										
Very useful	32	64	22	44	39	78	36	72	129	65
Somewhat useful	16	32	16	32	11	22	9	18	52	26
Not at all useful	2	4	12	24	0	0	5	10	19	10
Any family members participating in AWC activities										
No	31	62	50	100	48	96	39	78	168	84
Yes	19	38	0	0	2	4	11	22	32	16
Reasons for non- participation*										
No one asked	16	52	5	10	12	25	6	15	39	23
Don't know how	10	32	32	64	25	50	14	35	81	48
Don't want	0	0	0	0	0	0	17	43	17	10
Not our concern	2	7	12	24	10	20	2	5	26	15
AWC staff does not welcome	10	32	1	2	1	2	0	0	12	7
No response	3	10	0	0	0	0	0	0	3	2
Total not participating	**31**	**100**	**50**	**100**	**48**	**100**	**39**	**100**	**168**	**100**
Suggestions to improve services*										
Open regularly	49	98	49	98	24	48	37	74	159	80
Provide food daily	43	86	50	100	33	66	12	24	138	69
Provide ready to eat	10	20	42	84	39	78	3	6	94	47
Improve food quality	34	68	0	0	0	0	8	16	42	21
Hand-over AWCs to Panchayats	2	4	39	78	2	4	2	4	45	23
Involve community in monitoring	2	4	3	6	3	6	1	2	9	5
Shift location	1	2	0	0	0	0	0	0	1	1
Improve building	1	2	2	4	8	16	0	0	11	6
Improve facilities	1	2	7	14	2	4	8	16	18	9
Give more time to health education	2	4	9	18	3	6	0	0	14	7
Give more time to PSE	3	6	17	34	2	4	28	56	50	25
AWC should be made full time	46	92	33	66	0	0	0	0	79	40
Total	**50**	**100**	**50**	**100**	**50**	**100**	**50**	**100**	**200**	**100**

* Multiple responses.

Source: Planning Commission of India , New Delhi *

Appendix *III*



Courtesy:
Anton Parlow

The districts most affected by violence are: Srinagar (40%), Baramula (17%), Kupwara (11%), Anantnag (10%),Pulwama (7%), Shopian 5% and Budgam (3%). The ranking is based on own calculations in using the event data set I created. For the period 1990 to 2012 I have 1368 different events in total. 662 occurred in the period 1990 to 1996 only.

The districts most affected by violence are: Srinagar (40%), Baramula (17%), Kupwara (11%), Anantnag (10%), Pulwama (7%), Shopian 5% and Budgam (3%). The ranking is based on own calculations in using the event data set I created. For the period 1990 to 2012 I have 1368 different events in total. 662 occurred in the period 1990 to 1996 only.

Figure 2: Number of victims for J&K - 1988 to 2007 - own calculations

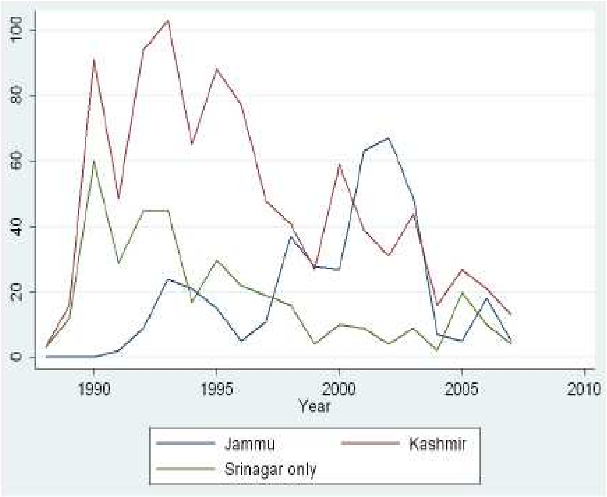


Figure 3: Number of victims for J&K - 1988 to 2011 - Source of raw data: SATP (2012)

: Number of victims for J&K - 1988 to 2011 - Source of raw data

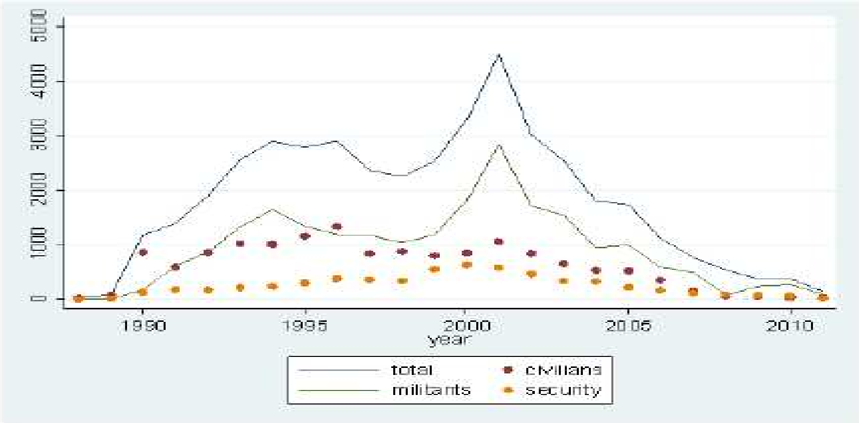
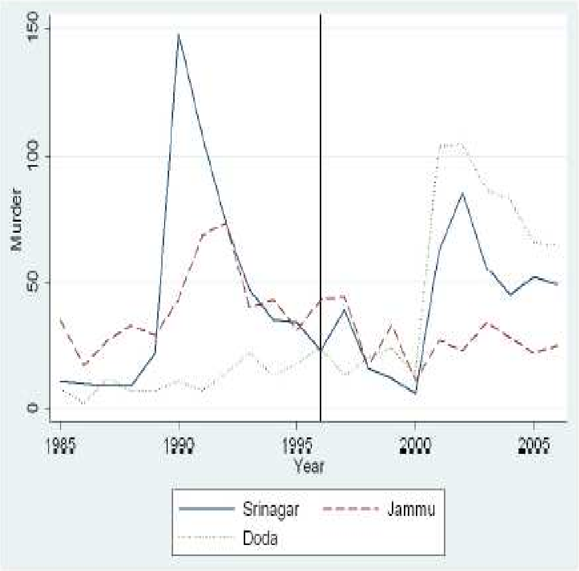
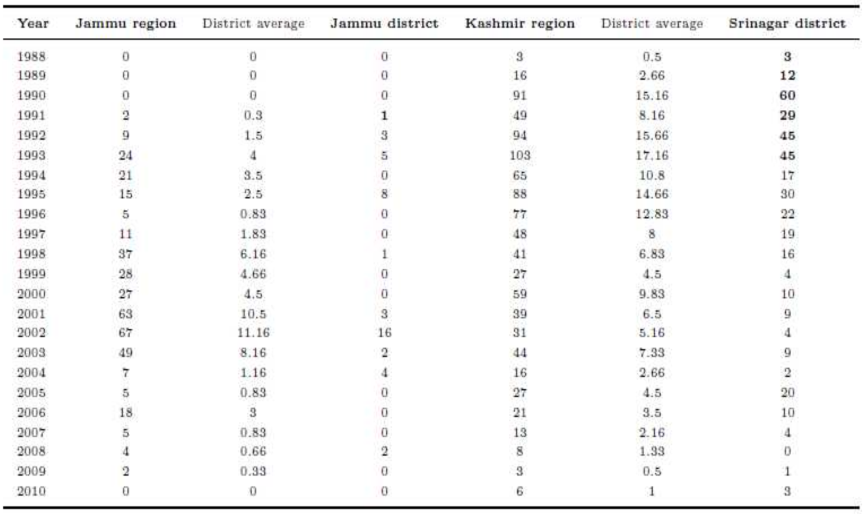


Figure 4: Number of murder victims for Srinagar, Jammu and Doda district 1990 to 2006 - Source of raw data: INSCR (2012)



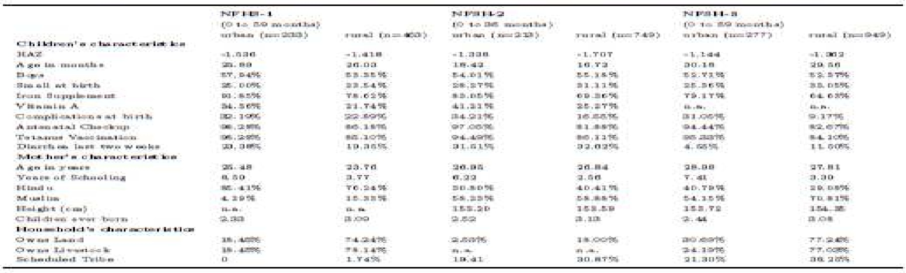
(Source: A research paper by Anton Parlow, Armed Conflict and Children's Health: The case of Kashmir, 10/31/2012)

Number of insurgency related incidences - 1988 to 2010 - own calculations



Year	**Jammu region**	District average	**Jammu district**	**Kashmir region**	District average	**Srinagar district**
1988	0	0	0	3	0.5	**3**
1989	0	0	0	16	2.66	**12**
1990	0	0	0	91	15.16	**60**
1991	2	0.3	**1**	49	8.16	**29**
1992	9	1.5	3	94	15.66	**45**
1993	24	4	5	103	17.16	**45**
1994	21	3.5	0	65	10.8	17
1995	15	2.5	8	88	14.66	30
1996	5	0.83	0	77	12.83	22
1997	11	1.83	0	48	8	19
1998	37	6.16	1	41	6.83	16
1999	28	4.66	0	27	4.5	4
2000	27	4.5	0	59	9.83	10
2001	63	10.5	3	39	6.5	9
2002	67	11.16	16	31	5.16	4
2003	49	8.16	2	44	7.33	9
2004	7	1.16	4	16	2.66	2
2005	5	0.83	0	27	4.5	20
2006	18	3	0	21	3.5	10
2007	5	0.83	0	13	2.16	4
2008	4	0.66	2	8	1.33	0
2009	2	0.33	0	3	0.5	1
2010	0	0	0	6	1	3

Table 2: Descriptive Statistics based on NHS-1, 2 and 3 for all Jammu and Kashmir



	NFHS-1 (0 to 59 months) urban (n=233)	rural (n=463)	NFSH-2 (0 to 35 months) urban (n=232)	rural (n=749)	NFSH-3 (0 to 59 months) urban (n=277)	rural (n=949)
Children's characteristics						
HAZ	-1.536	-1.418	-1.338	-1.707	-1.144	-1.362
Age in months	25.89	26.03	18.42	16.73	30.18	29.56
Boys	57.94%	53.35%	54.01%	55.18%	52.71%	52.57%
Small at birth	25.00%	23.54%	28.27%	31.11%	25.56%	33.05%
Iron Supplement	91.85%	78.62%	83.05%	69.36%	79.17%	64.63%
Vitamin A	34.56%	21.74%	41.31%	25.27%	n.a.	n.a.
Complications at birth	32.19%	22.89%	34.21%	16.55%	31.06%	9.17%
Antenatal Checkup	96.28%	86.18%	97.05%	81.88%	94.44%	82.67%
Tetanus Vaccination	96.28%	85.10%	94.49%	86.11%	95.23%	84.10%
Diarrhea last two weeks	23.38%	19.35%	31.61%	32.02%	4.55%	11.50%
Mother's characteristics						
Age in years	25.48	23.76	26.85	26.84	28.98	27.81
Years of Schooling	8.50	3.77	6.22	2.56	7.41	3.30
Hindu	95.41%	76.24%	30.80%	40.41%	40.79%	29.08%
Muslim	4.19%	15.33%	58.23%	58.88%	54.15%	70.81%
Height (cm)	n.a.	n.a.	153.20	152.59	152.72	154.35
Children ever born	2.33	3.09	2.52	3.18	2.44	3.08
Household's characteristics						
Owns Land	15.48%	74.24%	2.53%	18.00%	30.69%	77.24%
Owns Livestock	15.48%	78.14%	n.a.	n.a.	24.19%	77.08%
Scheduled Tribe	0	1.74%	19.41	30.87%	21.30%	38.25%

Note: Bold numbers indicate that absolute number of incidents is close or more than 50% of all incidents in this particular year. Here we are using this event-data set in conjunction with findings in the literature. The reason is that it is not possible to collect all violence related events without access to local archives. Especially the amount of incidences in the Jammu district underestimates the effect of the violence . Given the amount of riots, murder rates and looting early in the 90's in the Jammu district (INSCR 2012), it is surprising that not more violence related incidences are reported. One reason could be that only incidences in Kashmir made it into the literature, because the Azaadi movement is mainly a Kashmiri one , and the supported by Muslim belt of Jammu province . Nonetheless, Jammu city is the winter capital of the state including many government agencies which can be targets for militants. (Source: A research paper by Anton Parlow, Armed Conflict and Children's Health: The case of Kashmir, 10/31/2012)

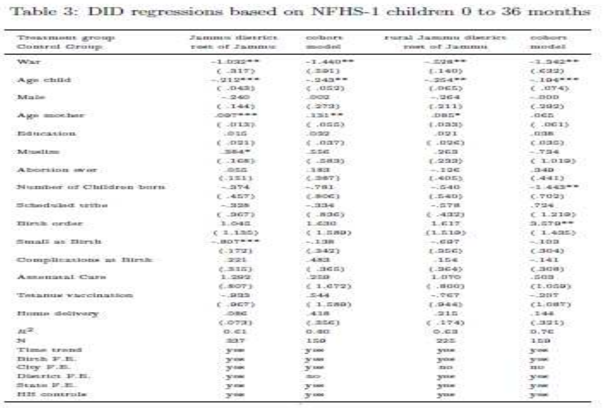


Table 3: DID regressions based on NFHS-1 children 0 to 36 months

Treatment group Control Group	Jammu district rest of Jammu	cohort model	rural Jammu district rest of Jammu	cohort model
War	-1.032**	-1.440**	-.528**	-1.542**
	(.317)	(.591)	(.140)	(.632)
Age child	-.212***	-.243**	-.254**	-.194***
	(.043)	(.052)	(.065)	(.074)
Male	-.240	.002	-.264	-.000
	(.144)	(.273)	(.211)	(.292)
Age mother	.097***	.131**	.085*	.065
	(.013)	(.055)	(.033)	(.061)
Education	.015	.032	.021	.038
	(.021)	(.037)	(.026)	(.035)
Muslim	.384*	.556	.263	-.734
	(.168)	(.583)	(.232)	(1.019)
Abortion ever	.055	.183	-.126	.349
	(.151)	(.387)	(.405)	(.441)
Number of Children born	-.374	-.781	-.540	-1.443**
	(.457)	(.806)	(.540)	(.702)
Scheduled tribe	-.328	-.334	-.578	.724
	(.367)	(.836)	(.432)	(1.219)
Birth order	1.042	1.630	1.617	3.579**
	(1.135)	(1.589)	(1.519)	(1.435)
Small at Birth	-.807***	-.138	-.697	-.103
	(.172)	(.342)	(.356)	(.304)
Complications at Birth	.221	.483	.154	-.141
	(.315)	(.365)	(.364)	(.308)
Antenatal Care	1.292	.259	1.070	.503
	(.807)	(1.672)	(.800)	(1.059)
Tetanus vaccination	-.933	.544	-.767	-.297
	(.967)	(1.589)	(.944)	(1.087)
Home delivery	.086	.418	.215	.144
	(.073)	(.356)	(.174)	(.321)
R^2	0.61	0.40	0.63	0.76
N	337	159	225	159
Time trend	yes	yes	yes	yes
Birth F.E.	yes	yes	yes	yes
City F.E.	yes	yes	no	no
District F.E.	yes	no	yes	yes
State F.E.	yes	yes	yes	yes
HH controls	yes	yes	yes	yes

Note: For the NFHS-1 years of schooling, assumed missing values in years of schooling to be zero. Given that the sample barely includes any members of a scheduled tribe, years of schooling likely overstates the true years of schooling. . (Source: A research paper by Anton Parlow, Armed Conflict and Children's Health: The case of Kashmir, 10/31/2012)

Note: Household controls include owning a TV (for urban areas) and owning land and livestock (for rural areas).The cohort model includes children living in the same district but compares outcomes of children age 0 to 35 months with an older cohort. Robust and clustered at the district level standard errors are shown in parentheses.* p<0.10, ** p<0.05, *** p<0.01

(Source: A research paper by Anton Parlow, Armed Conflict and Children's Health: The case of Kashmir, 10/31/2012)

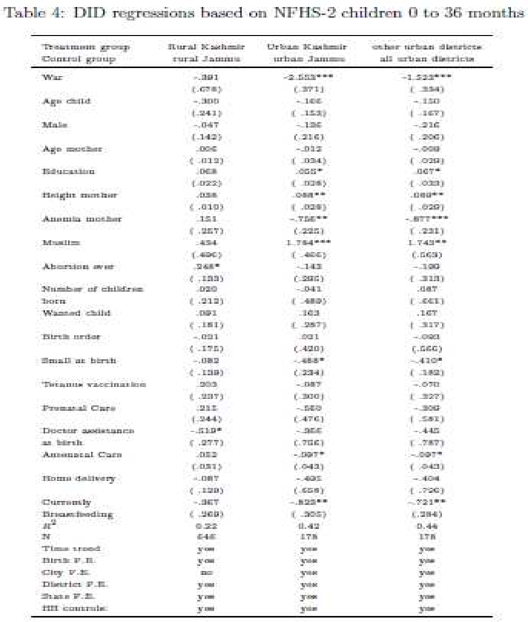


Table 4: DID regressions based on NFHS-2 children 0 to 36 months

Treatment group Control group	Rural Kashmir rural Jammu	Urban Kashmir urban Jammu	other urban districts all urban districts
War	-.391	-2.553***	-1.523***
	(.678)	(.371)	(.334)
Age child	-.300	-.166	-.150
	(.241)	(.153)	(.167)
Male	-.047	-.126	-.216
	(.142)	(.216)	(.206)
Age mother	.006	-.012	-.009
	(.012)	(.034)	(.039)
Education	.068	.055*	.067*
	(.022)	(.038)	(.033)
Height mother	.038	.088**	.089**
	(.010)	(.028)	(.029)
Anemia mother	.151	-.756**	-.877***
	(.257)	(.225)	(.231)
Muslim	.434	1.764***	1.743**
	(.496)	(.466)	(.563)
Abortion ever	.248*	-.143	-.199
	(.153)	(.285)	(.313)
Number of children born	.020	-.041	.087
	(.212)	(.489)	(.661)
Wanted child	.091	.163	.167
	(.181)	(.287)	(.317)
Birth order	-.021	.021	-.093
	(.175)	(.420)	(.566)
Small at birth	-.082	-.488*	-.410*
	(.139)	(.234)	(.182)
Tetanus vaccination	.303	-.087	-.070
	(.337)	(.300)	(.327)
Prenatal Care	.215	-.583	-.302
	(.244)	(.476)	(.581)
Doctor assistance at birth	-.519*	-.366	-.445
	(.277)	(.756)	(.787)
Antenatal Care	.052	-.097*	-.097*
	(.051)	(.043)	(.043)
Home delivery	-.087	-.495	-.404
	(.139)	(.658)	(.726)
Currently Breastfeeding	-.367	-.823**	-.721**
	(.369)	(.305)	(.284)
R^2	0.22	0.42	0.44
N	646	178	178
Time trend	yes	yes	yes
Birth F.E.	yes	yes	yes
City F.E.	no	yes	yes
District F.E.	yes	yes	yes
State F.E.	yes	yes	yes
HH controls	yes	yes	yes

Note : household belongs to a scheduled class or not altitude, do not present cohort models because the NFHS-2 only includes children age 0 to 36 months. Robust and clustered at the district level standard errors are shown in parentheses.* p<0.10, ** p<0.05, *** p<0.01

(Source: A research paper by Anton Parlow, Armed Conict and Children's Health: The case of Kashmir, 10/31/2012)

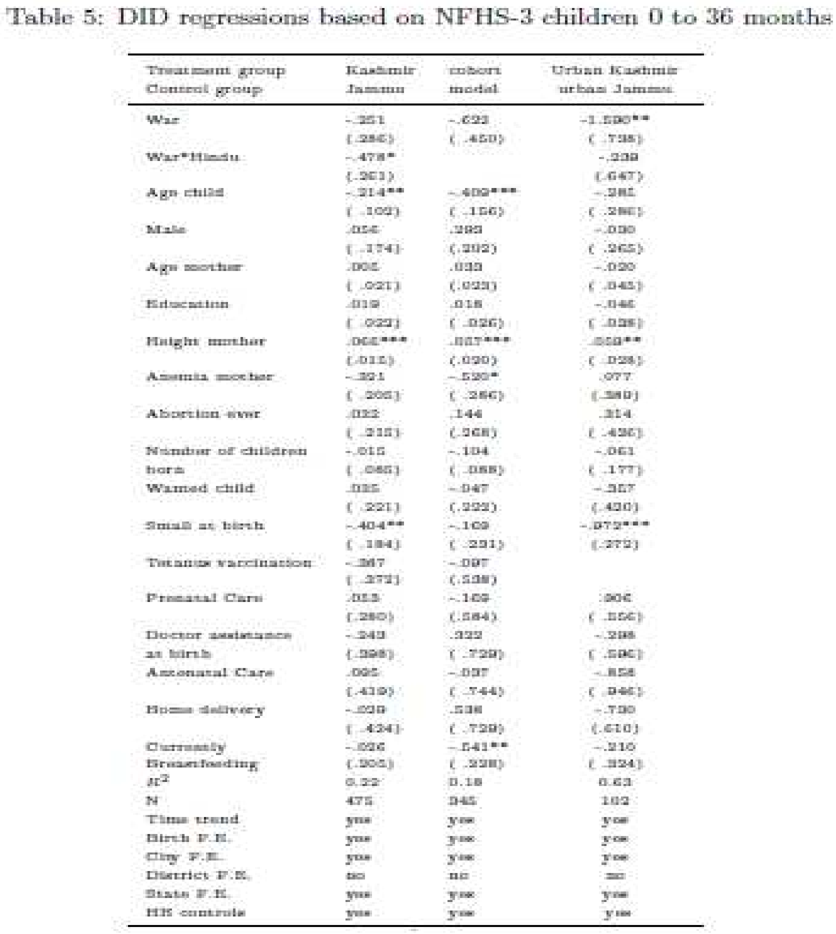
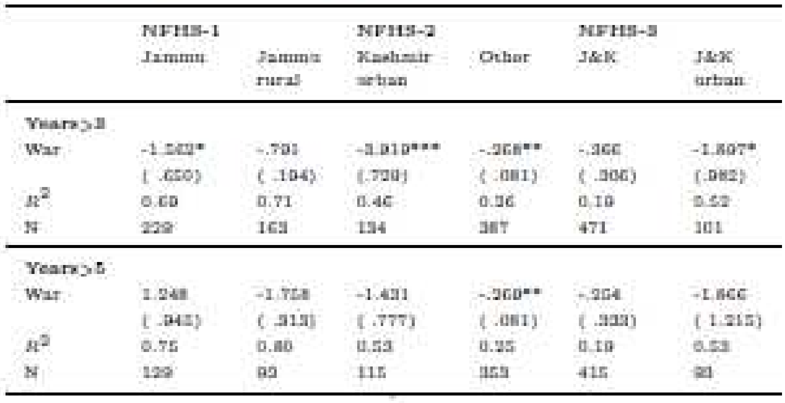


Table 5: DID regressions based on NFHS-3 children 0 to 36 months

Treatment group Control group	Kashmir Jammu	cohort model	Urban Kashmir urban Jammu
War	-.251	-.622	-1.590**
	(.286)	(.450)	(.738)
War*Hindu	-.478*		-.239
	(.263)		(.647)
Age child	-.214**	-.409***	-.281
	(.109)	(.156)	(.286)
Male	.056	.293	-.030
	(.174)	(.292)	(.265)
Age mother	.005	.033	-.020
	(.021)	(.023)	(.045)
Education	.019	.018	-.046
	(.022)	(.026)	(.038)
Height mother	.062***	.057***	.059**
	(.015)	(.020)	(.028)
Anemia mother	-.321	-.520*	.077
	(.205)	(.286)	(.380)
Abortion ever	.032	.144	.314
	(.215)	(.268)	(.436)
Number of children born	-.015	-.104	-.061
	(.085)	(.088)	(.177)
Wanted child	.035	-.047	-.357
	(.221)	(.222)	(.420)
Small at birth	-.404**	-.169	-.872***
	(.184)	(.231)	(.272)
Tetanus vaccination	-.367	-.097	
	(.272)	(.538)	
Prenatal Care	.053	-.169	.906
	(.280)	(.584)	(.556)
Doctor assistance at birth	-.243	.322	-.298
	(.398)	(.729)	(.596)
Antenatal Care	.095	-.037	-.858
	(.439)	(.744)	(.946)
Home delivery	-.029	.538	-.730
	(.424)	(.729)	(.610)
Currently Breastfeeding	-.026	-.541**	-.210
	(.305)	(.228)	(.324)
R^2	0.22	0.18	0.63
N	475	345	102
Time trend	yes	yes	yes
Birth F.E.	yes	yes	yes
City F.E.	yes	yes	yes
District F.E.	no	no	no
State F.E.	yes	yes	yes
HH controls	yes	yes	yes

Source: A research paper by Anton Parlow, Armed Conict and Children's Health: The case of Kashmir, 10/31/2012)

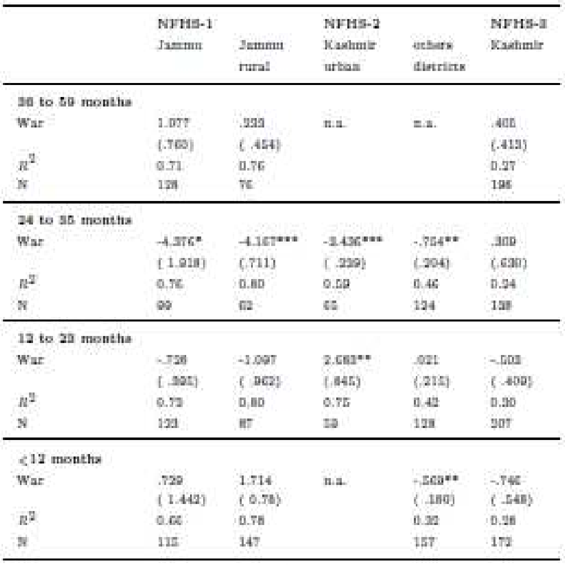
Table 6: Migration - Years living at current residence - NFHS-1, 2 and 3



	NFHS-1		NFHS-2		NFHS-3	
	Jammu	Jammu rural	Kashmir urban	Other	J&K	J&K urban
Years$\geq$3						
War	-1.562*	-.791	-3.910***	-.268**	-.366	-1.807*
	(.650)	(.194)	(.720)	(.081)	(.306)	(.982)
R^2	0.69	0.71	0.46	0.36	0.19	0.52
N	229	163	134	387	471	101
Years$\geq$5						
War	1.248	-1.758	-1.431	-.260**	-.254	-1.866
	(.942)	(.313)	(.777)	(.081)	(.333)	(1.215)
R^2	0.75	0.80	0.53	0.35	0.19	0.53
N	129	89	115	353	415	93

(Source: A research paper by Anton Parlow, Armed Conict and Children's Health: The case of Kashmir, 10/31/2012)

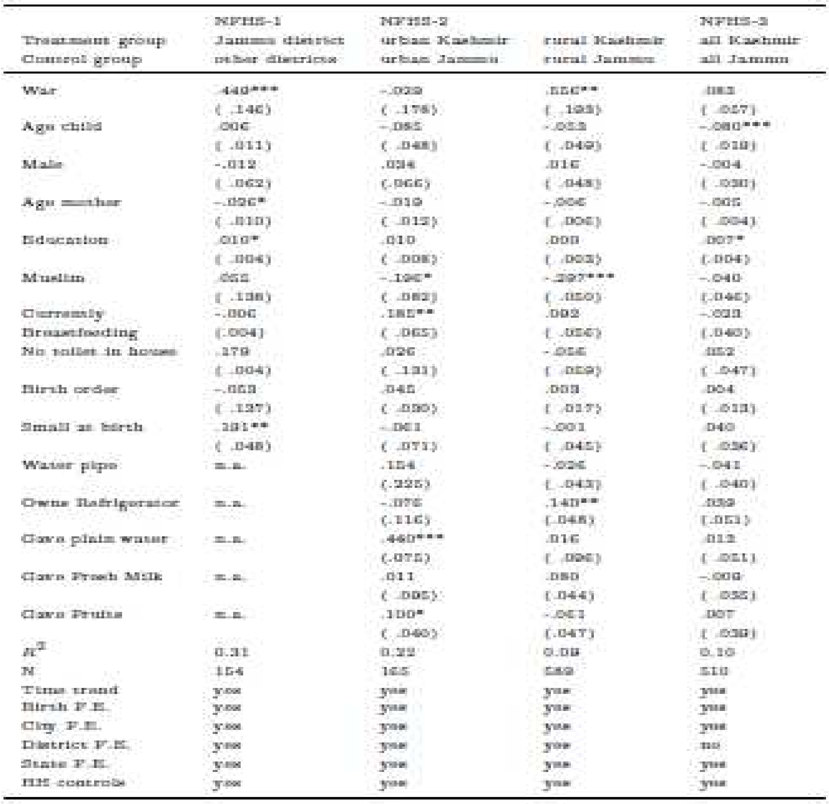
Table 7: Exposure to violence by birth cohorts - NFHS-1, 2 and 3



	NFHS-1		NFHS-2		NFHS-3
	Jammu	Jammu rural	Kashmir urban	others districts	Kashmir
36 to 59 months					
War	1.077	.333	n.a.	n.a.	.405
	(.760)	(.454)			(.413)
R^2	0.71	0.76			0.27
N	128	76			196
24 to 35 months					
War	-4.376*	-4.167***	-3.436***	-.704**	.309
	(1.918)	(.711)	(.339)	(.204)	(.630)
R^2	0.76	0.80	0.59	0.46	0.24
N	99	62	65	124	138
12 to 23 months					
War	-.726	-1.097	2.083**	.021	-.503
	(.395)	(.962)	(.845)	(.213)	(.409)
R^2	0.73	0.80	0.75	0.42	0.30
N	123	87	59	128	207
<12 months					
War	.729	1.714	n.a.	-.569**	-.746
	(1.442)	(0.78)		(.180)	(.548)
R^2	0.66	0.78		0.32	0.28
N	115	147		157	172

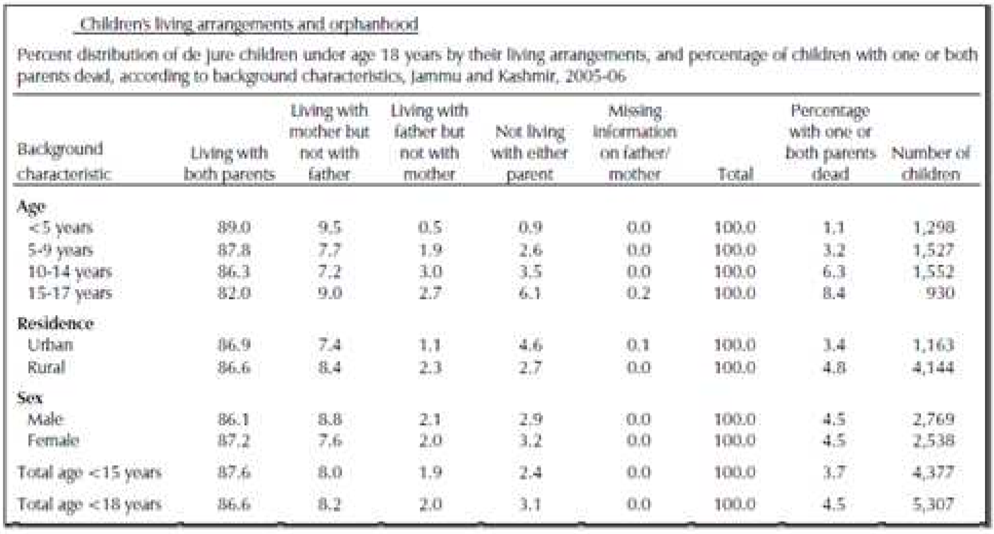
(Source: A research paper by Anton Parlow, Armed Conflict and Children's Health: The case of Kashmir, 10/31/2012)

Table 8: Other dimensions of health - Diarrhea outcomes two weeks prior to the survey



Treatment group Control group	NFHS-1 Jammu district other districts	NFHS-2 urban Kashmir urban Jammu	rural Kashmir rural Jammu	NFHS-3 all Kashmir all Jammu
War	.440***	-.029	.556**	.083
	(.146)	(.178)	(.193)	(.057)
Age child	.006	-.085	-.053	-.080***
	(.011)	(.048)	(.049)	(.019)
Male	-.012	.034	.016	-.004
	(.062)	(.066)	(.048)	(.030)
Age mother	-.026*	-.019	-.006	-.005
	(.010)	(.012)	(.006)	(.004)
Education	.010*	.010	.008	.007*
	(.004)	(.008)	(.003)	(.004)
Muslim	.052	-.196*	-.297***	-.040
	(.136)	(.082)	(.050)	(.046)
Currently	-.006	.185**	.092	-.023
Breastfeeding	(.004)	(.065)	(.056)	(.040)
No toilet in house	.179	.026	-.056	.052
	(.004)	(.131)	(.059)	(.047)
Birth order	-.053	.045	.003	.004
	(.137)	(.030)	(.017)	(.013)
Small at birth	.191**	-.061	-.001	.040
	(.048)	(.071)	(.045)	(.036)
Water pipe	n.a.	.154	-.026	-.041
		(.225)	(.043)	(.040)
Owns Refrigerator	n.a.	-.076	.140**	.039
		(.116)	(.048)	(.051)
Gave plain water	n.a.	.460***	.016	.012
		(.075)	(.096)	(.051)
Gave Fresh Milk	n.a.	.011	.080	-.009
		(.095)	(.044)	(.035)
Gave Fruits	n.a.	.100*	-.061	.007
		(.040)	(.047)	(.039)
R^2	0.31	0.22	0.08	0.10
N	154	165	589	510
Time trend	yes	yes	yes	yes
Birth F.E.	yes	yes	yes	yes
City F.E.	yes	yes	yes	yes
District F.E.	yes	yes	yes	no
State F.E.	yes	yes	yes	yes
HH controls	yes	yes	yes	yes

(Source: A research paper by Anton Parlow, Armed Conflict and Children's Health: The case of Kashmir, 10/31/2012)



Children's living arrangements and orphanhood

Percent distribution of de jure children under age 18 years by their living arrangements, and percentage of children with one or both parents dead, according to background characteristics, Jammu and Kashmir, 2005-06

Background characteristic	Living with both parents	Living with mother but not with father	Living with father but not with mother	Not living with either parent	Missing information on father/ mother	Total	Percentage with one or both parents dead	Number of children
Age								
<5 years	89.0	9.5	0.5	0.9	0.0	100.0	1.1	1,298
5-9 years	87.8	7.7	1.9	2.6	0.0	100.0	3.2	1,527
10-14 years	86.3	7.2	3.0	3.5	0.0	100.0	6.3	1,552
15-17 years	82.0	9.0	2.7	6.1	0.2	100.0	8.4	930
Residence								
Urban	86.9	7.4	1.1	4.6	0.1	100.0	3.4	1,163
Rural	86.6	8.4	2.3	2.7	0.0	100.0	4.8	4,144
Sex								
Male	86.1	8.8	2.1	2.9	0.0	100.0	4.5	2,769
Female	87.2	7.6	2.0	3.2	0.0	100.0	4.5	2,538
Total age <15 years	87.6	8.0	1.9	2.4	0.0	100.0	3.7	4,377
Total age <18 years	86.6	8.2	2.0	3.1	0.0	100.0	4.5	5,307

Source: National Family Health 2005-06 Survey (NFHS-3)India

Appendix IV

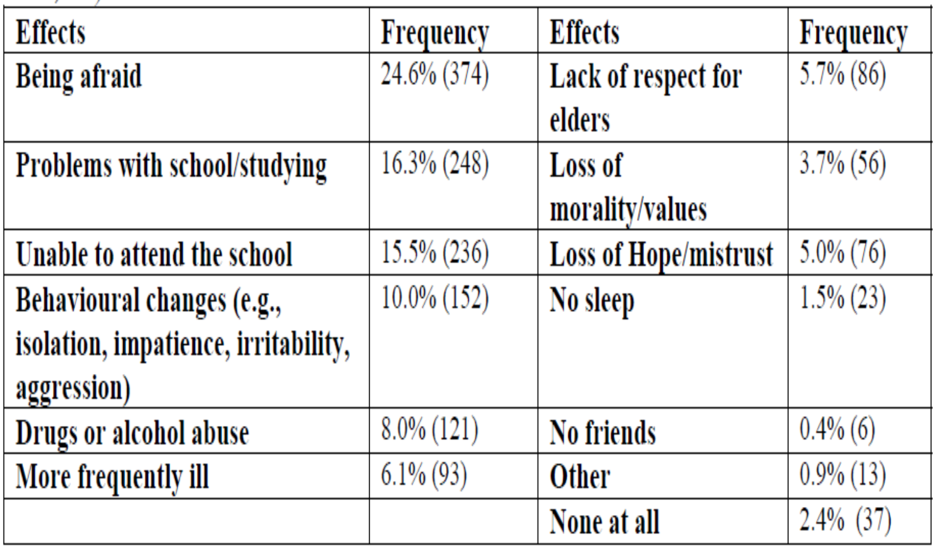
Detailed export of Kashmiri shawls , outside India

1851	£ 171,709
1852	£ 146,270
1853	£ 215,659
1854	£170,153
1855	£197,890
1856	£209,279
1857	£290,640
1858	£227,618
1859	£310,027
1860	£252,828
1861	£351,093
1862	£459,441
1863	£303,157
1864	£275,391

Source : Robert Thorp, Kashmir Misgovernment

Appendix V

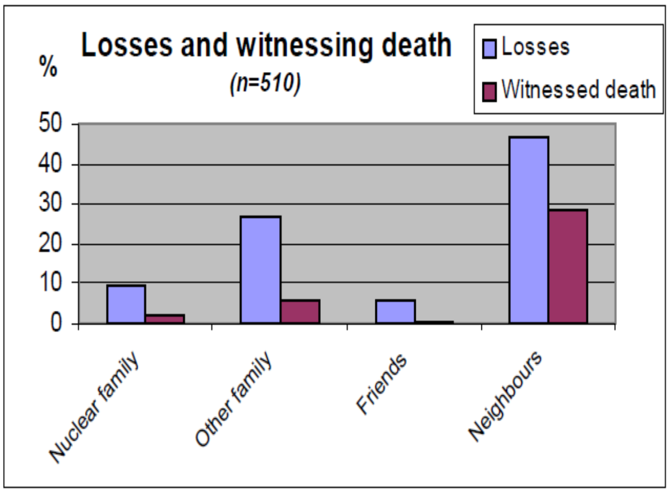
Table 3: Consequences of violence on children (% taken from total number of responses, n=1,521)



Effects	Frequency	Effects	Frequency
Being afraid	24.6% (374)	Lack of respect for elders	5.7% (86)
Problems with school/studying	16.3% (248)	Loss of morality/values	3.7% (56)
Unable to attend the school	15.5% (236)	Loss of Hope/mistrust	5.0% (76)
Behavioural changes (e.g., isolation, impatience, irritability, aggression)	10.0% (152)	No sleep	1.5% (23)
Drugs or alcohol abuse	8.0% (121)	No friends	0.4% (6)
More frequently ill	6.1% (93)	Other	0.9% (13)
		None at all	2.4% (37)

Source: Medecins Sans Frontieres(MSF) , Kashmir: violence and health, November 2006

Graph 3: Reported deaths and witnessing of violent deaths since 1989.
(The " witnessed deaths" is the proportion of persons who witnessed deaths to total number of persons experienced in each category)



Source: Medecins Sans Frontieres(MSF) ,   Kashmir: violence and health, November 2006, p 16

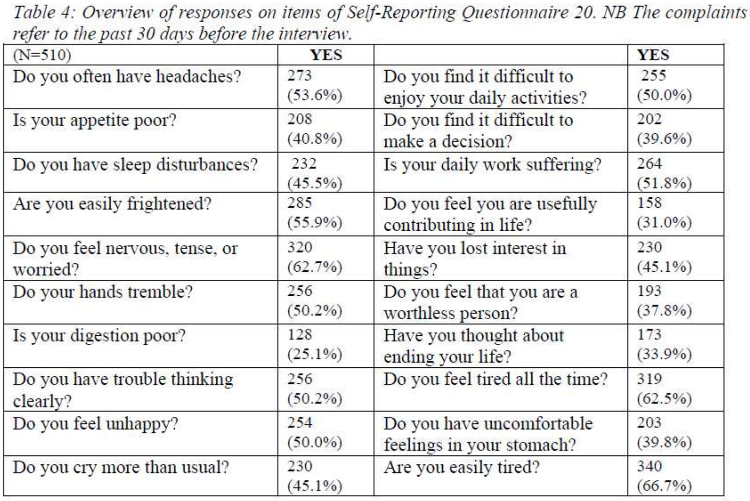


Table 4: Overview of responses on items of Self-Reporting Questionnaire 20. NB The complaints refer to the past 30 days before the interview.

(N=510)	YES		YES
Do you often have headaches?	273 (53.6%)	Do you find it difficult to enjoy your daily activities?	255 (50.0%)
Is your appetite poor?	208 (40.8%)	Do you find it difficult to make a decision?	202 (39.6%)
Do you have sleep disturbances?	232 (45.5%)	Is your daily work suffering?	264 (51.8%)
Are you easily frightened?	285 (55.9%)	Do you feel you are usefully contributing in life?	158 (31.0%)
Do you feel nervous, tense, or worried?	320 (62.7%)	Have you lost interest in things?	230 (45.1%)
Do your hands tremble?	256 (50.2%)	Do you feel that you are a worthless person?	193 (37.8%)
Is your digestion poor?	128 (25.1%)	Have you thought about ending your life?	173 (33.9%)
Do you have trouble thinking clearly?	256 (50.2%)	Do you feel tired all the time?	319 (62.5%)
Do you feel unhappy?	254 (50.0%)	Do you have uncomfortable feelings in your stomach?	203 (39.8%)
Do you cry more than usual?	230 (45.1%)	Are you easily tired?	340 (66.7%)

Source: Medecins Sans Frontieres(MSF) ,   Kashmir: violence and health, November 2006, p 17

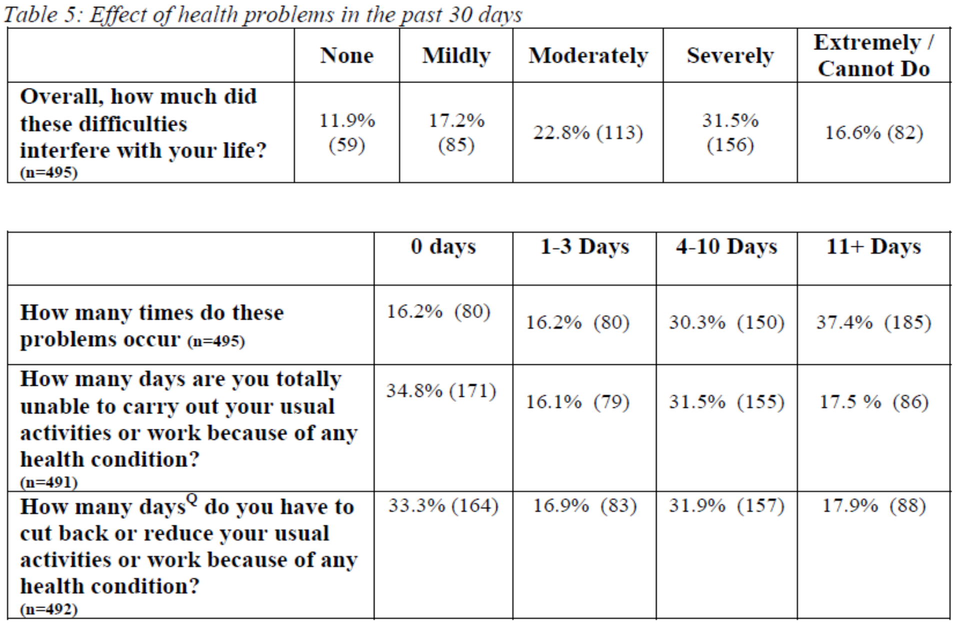


Table 5: Effect of health problems in the past 30 days

	None	Mildly	Moderately	Severely	Extremely / Cannot Do
Overall, how much did these difficulties interfere with your life? (n=495)	11.9% (59)	17.2% (85)	22.8% (113)	31.5% (156)	16.6% (82)

	0 days	1-3 Days	4-10 Days	11+ Days
How many times do these problems occur (n=495)	16.2% (80)	16.2% (80)	30.3% (150)	37.4% (185)
How many days are you totally unable to carry out your usual activities or work because of any health condition? (n=491)	34.8% (171)	16.1% (79)	31.5% (155)	17.5 % (86)
How many days[Q] do you have to cut back or reduce your usual activities or work because of any health condition? (n=492)	33.3% (164)	16.9% (83)	31.9% (157)	17.9% (88)

Source: Medecins Sans Frontieres(MSF) , Kashmir: violence and health, November 2006, p 18

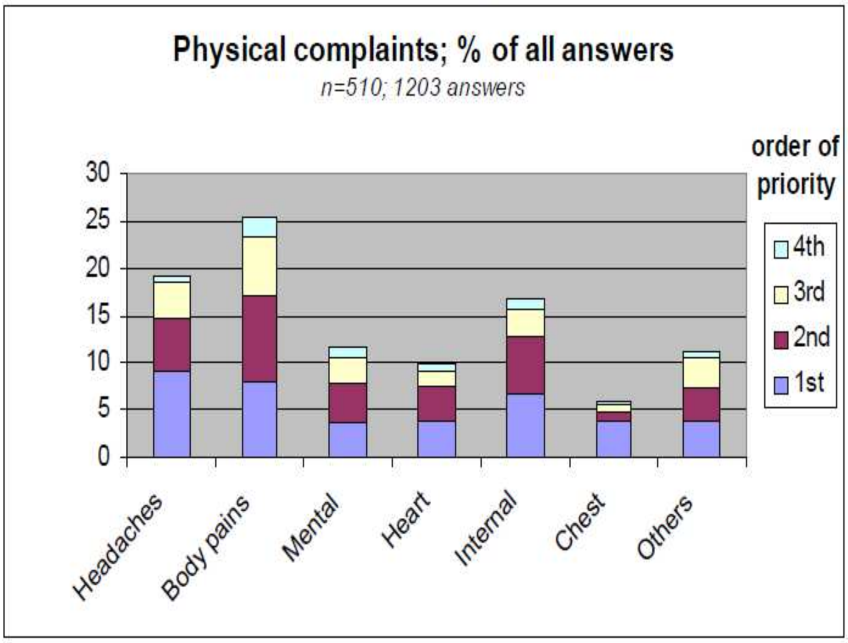
Table 6: Overview of health responses. The reference period is the last 30 days.

Perception of own health (n=510)	**Very good**	**Good**	**Moderate**	**Poor**	**Very poor**
	11.8% (60)	23.3% (119)	35.1% (179)	22.7% (116)	7.1% (36)

Number of complaints (n=508)	**None**	**0-2 Times**	**3-6 Times**	**6+ Times**
	29.3% (149)	14.4 (73)	22% (112)	34.3% (174)
Visit health clinic (n=501)	**Not at all**	**1 Time**	**2-3 Times**	**4+ Times**
	34.9% (175)	18.2% (91)	31.5% (158)	15.4% (77)
Quality health facility (n=508)	**Excellent**	**Good**	**Acceptable**	**Poor**
	3.7% (19)	24.0% (122)	22.4% (114)	49.8% (253)
Medicine consumption (n=499)	**Not at all**	**1-3 Times**	**4-6 Times**	**6+ Times**
	28.9% (144)	14.6% (73)	18.6% (93)	37.9% (189)

Source: Medecins Sans Frontieres(MSF) , Kashmir: violence and health, November 2006, p 20

Graph 5: Health complaints in the past 30 days in order of priority (maximum of four answers per interviewee, % from total number of answers: 1203)



Source: Medecins Sans Frontieres(MSF) ,   Kashmir: violence and health, November 2006, p 20